

# Medicare Program Integrity Manual

Department of Health and  
Human Services (DHHS)  
HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)

Transmittal 3

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CHANGE REQUEST 1292

<u>CHAPTERS</u>	<u>REVISED SECTIONS</u>	<u>NEW SECTIONS</u>	<u>DELETED SECTIONS</u>
1-9	All		
Exhibits	All		

**CLARIFICATION--EFFECTIVE/IMPLEMENTATION DATE: 30 days after issuance**

This transmittal replaces PIM Revision 1 in its entirety.

Material in Chapters 1-9 and the exhibits has in many instances been relocated or reorganized or had minor wording changes but in these situations has not changed substantively. All substantive changes are noted below. Due to the large volume of minor wording changes and sections being reformatted and moved from one area to another, redlining has been omitted from this version of the PIM and instead this transmittal cover sheet provides a very detailed listing of the changes. All future PIM revision will contain redlining to indicate new and changed material.

The changes have been divided into 4 groups: Major Changes, Minor Changes, Moved Language, and Deleted Language.

## MAJOR CHANGES

The following significant changes have been made:

**Chapter 1, §1.2, Types of Claims For Which Contractors Are Responsible** -- clarifies that Fiscal Intermediaries are generally not responsible for medical review (MR) functions in inpatient hospital claims.

**Chapter 1, §2, The Medicare MR Program** -- adds a requirement for all contractors to develop and submit to HCFA RO and CO an Annual MR Strategy (a Budget and Performance Requirement provision).

**Chapter 1, §2.1, National Coverage Policy (NCP) and Local Medical Review Policy (LMRP) and Individual Claim Determinations** -- Previous instructions stated that intermediaries' LMRPs were limited to issues involving reasonable and necessary (section 1862(a)(1)(A) of The Act) determinations. This instruction clarifies that intermediaries' LMRPs may address all types of coverage determinations including benefit category and statutory exclusion determinations.

**Chapter 1, §2.1.C, Individual Claim Determinations** -- Reiterates that contractors may review claims even in the absence of NCP or LMRP but clarifies that automated denials cannot be made in the absence of NCP or LMRP.

**Chapter 1, §2.3.1, Identification of Services for Which An LMRP Is Needed** -- directs contractors to prioritize their LMRP development efforts to those services that present the major financial risk to the Medicare program. This makes the PIM consistent with the BPR provisions.

**Chapter 1, §2.3.4, Coding Rules in LMRPs** -- clarifies that LMRPs may describe national and/or local coding rules that pertain to a service.

**Chapter 1, §2.3.6, LMRP Notice Process** -- adds posting LMRPs to contractor websites as an acceptable mechanism to give LMRP notice to the provider community.

**Chapter 1, §2.6, Manual Review Personnel and Levels of Review** -- adds "LPNs" and "other types of clinicians" to the list of manual review personnel. Adds a requirement that contractors use health professionals to review all claims that are medically complex. Removes the term "RN" from the "Clinician Review" section thereby clarifying that LPNs can conduct these reviews. Eliminates the requirement to have a specified number of RNs on staff. These changes make the PIM consistent with BPR provisions.

**Chapter 1, §2.7.1, The CAC** -- allows carriers that develop identical LMRPs in a region to establish a single Contractor Advisory Committee (CAC) with permission from the RO and consensus from all CAC members in the region. This change will further reduce unnecessary variation among LMRPs.

**Chapter 1, §3.2.5, and Section 3.1.5.1, Medicare Fraud Information Specialist** -- provides new instruction on alignment and duties of the MFIS.

**Chapter 1, §5.1 MIP-PET Activities** -- manualizes the BPR provisions that pertain to the Medicare Integrity Program (MIP) Provider Education and Training (PET) activities.

**Chapter 1, §6, Contractor Medical Director (CMD)** -- requires FI to have one FTE CMD. Allows ROs to grant waivers for small FIs. Removes assisting the claim review activities from the list of CMD required functions as this could activity could be performed by medical consultants and need not necessarily be performed by the CMD. Removes the requirement that CMDs attend national and multi-regional meetings as these may be attended at the CMDs discretion. Adds to the list of CMD functions providing clinical expertise and serving as a readily available source of medical information to provide guidance in questionable situations. Adds email as an additional vehicle for CMDs to notify HCFA.

**Chapter 2, §6, OIG Referrals and Appropriate FID Entries** -- adds new language regarding OIG referrals and how contractors get access to the Fraud Information Database.

**Chapter 3, §1, Introduction** – has been clarified to incorporate the concept known as progressive corrective action (PCA). The PCA philosophy involves ensuring that contractor administrative actions are commensurate with the nature and extent of the provider's billing problem.

**Chapter 3, §1.1, Provider Tracking System (PTS)** -- Previous instructions required carriers to have a PTS. This instruction extends that requirements to FIs requiring that such a system be in place by January 1, 2002.

**Chapter 3, §1.2, Evaluating Effectiveness of Corrective Actions** -- Previous instructions directed contractors to evaluate the effectiveness of their prepayment edits. This provision expands that requirement to include evaluation of the effectiveness of all the contractors' corrective actions to make the PIM consistent with the PCA concept.

**Chapter 3, §2, Verifying Potential Errors and Setting Priorities; Section 2.1, Determining Whether the Problem is Widespread or Provider-Specific** – has been added to explain the PCA activities called "error validation reviews," "priority setting," and "determining if the problem is widespread or provider-specific."

**Chapter 3, §3, Provider Education** -- clarifies that "focused provider education" means direct 1:1 contact between the contract and the provider through a phone call, letter, or meeting. Clarifies that non-covered services must be denied even while education is occurring and that when overpayments are identified, contractors must take steps to collect the overpayment.

**Chapter 3, §5, Prepayment Review of Selected Claims** -- clarifies that coding reviews may be performed, reminds contractors to select for prepayment review those claims that have a higher potential for being non-covered or misrepresented, and directs contractors to consider appeals information when evaluating prepayment edits.

**Chapter 3, §5.1, Automated and Manual Prepayment Review** -- Reiterates that contractors may review claims even in the absence of NCP or LMRP but clarifies that automated denials cannot be made in the absence of NCP or LMRP.

**Chapter 3, §5.1.1, Prepayment Edits** -- Previous instructions required carrier systems to have the capability to compare procedure-to-procedure, procedure-to-provider, frequency-to-time, diagnosis-to-procedure, procedure-to-specialty/TOB, and procedure-to-place of service. This instruction extends this requirement to FIs by January 2001. The systems change that will accomplish this is known as "Oregon Nine."

**Chapter 3, §5.3.3, Development of Claims for Additional Documentation** -- Previous instructions directed intermediaries to notify pend the claim for 35 days while waiting for additional documentation and was silent regarding carrier timeframes. This instruction remains the same for intermediaries but directs the carriers to pend the claim for 45 days in such circumstances.

**Chapter 3 §8.3.2, Location of Postpay Reviews** -- makes optional the requirement that requests for medical records are to be sent via certified mail/return receipt.

**Chapter 5, §7, Advance Determination of Medicare Coverage (ADMC) of Customized DME** -- manualizes the statutory requirement that DMERCs provide advance determinations for Medicare coverage for customized DME. Defines the term "customized DME". Eliminates the requirement (and makes it optional at the DMERCs discretion) for DMERCs to give ADMCs for transcutaneous electrical nerve stimulators. Requires the DMERCs to publish examples of the types of items for which ADMCs are available. Describes how suppliers or beneficiaries may submit requests for ADMC and provides instructions to DMERCs for processing and tracking such requests.

**Chapter 6, §3.6, Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined To Home"** -- adds guidance to RHHIs regarding how to conduct medical review once a beneficiary has received a favorable final appellate decision related to "confined to home."

### **MINOR CHANGES**

The following formatting, grammatical, and minor language changes have been made:

#### **All Chapters**

- Active voice is used where possible
- The word "claim" is used instead of "bill"
- "OI" is now referred to as "OIG/OI"
- Updates component titles (e.g. changes Health Standards and Quality Bureau to Office of Clinical Standards and Quality)

**Chapter 1, §1, Introduction** – adds language from the MR BPR.

**Chapter 1, §2, The Medicare MR Program** -- adds references regulatory authority for the MR program. Replaces the word "abuse" with "errors". Deletes "Overpayment recoupment" from the list of goals of the MR program. Some examples of errors have been added, some have been deleted.

**Chapter 1, §2.1, National Coverage Policy (NCP) and Local Medical Review Policy (LMRP) and Individual Claim Determinations** – Previous instructions directed contractors to notify the provider community of changes to NCP as soon as possible. These instructions clarify this to mean no later than the next provider bulletin. Adds instructions on how providers and contractors can submit requests for national coverage policy has been added. Clarifies that LMRPs specify whether a service is covered and correctly coded. Clarifies that contractors may adopt LMRPs that have been developed individually or collaboratively with other contractors. Clarifies that any statements about coverage or coding that a contractor puts in a bulletin must first be in a NCP or LMRP (a BPR provision). Clarifies that contractors may review any claim on either a prepayment or postpayment basis, regardless of whether a NCP or LMRP exists for that service. Adds the instruction that DMERCs solicit comments for LMRPs through the DMERC Advisory Panel (DAP).

**Chapter 1, §2.7.5, CAC Structure** -- Previous instructions required contractors to send meeting materials to CAC members 10-14 days in advance. The new requirement is 14 days. Adds email as an additional vehicle for obtaining comments on draft LMRPs between CAC meetings.

**Chapter 1, §2.7.6, CAC Process** – Previous instructions directed carriers to hold a minimum of 3-4 CAC meetings per year. This has been clarified to 3. Changes to email the vehicle for submitting minutes to CO.

**Chapter 1, §3, The Medicare Fraud Program** -- Clarifies that all cases of potential fraud are referred to the OIG. Instructs the fraud unit that has determined that a situation is not fraud, to refer these situations to the MR unit for corrective action.

**Chapter 1, §3.2.6.D, Staffing of the Fraud Unit and Security Training** -- Requires that persons working in the fraud unit should be paid comparable salaries to those in other areas of contractor operation.

**Chapter 1, §3.3, DMERC Fraud Functions** -- Adds a regulatory citation. Deletes a previous requirement that cases involving providers who fail to correct their practices after an education contact and warning letter must be referred to the fraud unit. Instead, appropriate correction action (which could include placing the provider on prepayment or postpayment medical review) should be taken.

**Chapter 2, §1, Identifying Potential Errors - Introduction** -- Instructs contractors to evaluate potential errors and not take administrative action unless they have verified the error and determined that the error is a high enough priority to justify the action.

**Chapter 2, §2, Data Analysis** -- references to aberrancies from the norm, abuse, abusive or potential fraudulent billings are now called potential errors. Changes "Fraud program" to "BI program". Adds information on a data analysis program (what it must involve, the goals, documenting the program and implementing the program).

**Chapter 2, §2.1.1, Resources Needed for Data Analysis** -- replaces the term "FMR" with "data analysis".

**Chapter 2, §2.4.1, Determine Indicators to Identify Norms and Deviations** -- deletes reference to Ratio I Report and Ratio II Report.

**Chapter 3, §4, Overview of Prepayment and Postpayment Review** -- provides an overview of prepayment and postpayment review.

**Chapter 3, §5.1, Automated and Manual Prepayment Review** – The use of physician consultants and other health professionals to review claims and medical documentation has been added.

**Chapter 3, §5.2, Categories of MR Edits** – Category I, Category II, and Category III edits have been replaced with service-specific edits, provider-specific system edits and random edits.

**Chapter 3, §8.1, Overpayment Assessment Procedures** -- CMR changed to SVRS.

**Chapter 3, §8.3.3, Consent Settlement Offer Based on Potential Projected Overpayment** -- CMR has been changed to SVRS.

**Chapter 5, §1.1.4 (a), CMN as the Written Order** – adds requirements regarding Cover letters for CMNs, Completing A CMN, and the DMERCs’ Authority to Assess an Overpayment and/or CMP When Invalid CMNs are Identified

**Chapter 5, §3.2.1.1, Pick-up slips** -- provides DMERCs with additional guidance in creating and applying safeguards to DME claims.

**Chapter 5, §4, Incurred Expenses for DME and Orthotic and Prosthetic Devices** – last sentence has been added. “Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied.”

**Chapter 7, §10, List of MR Codes, Categories, and Conversion Factors for FY 2000** – has been updated.

**Exhibit 3, Description of CAC** -- adds Infectious Disease and Nuclear Medicine as new specialties and subspecialties for physician representation on the Carrier Advisory Committee (CAC). Revises a typo in the term "Physical Medicine and Rehabilitation."

**Exhibit 15, Consent Settlement Documents** -- increases providers’ response time for from 30 days to 60 days.

**Exhibit 23, PIM Acronyms** -- provides a list and meaning of acronyms found in the PIM.

**Exhibit 24, HCFA Forms 700 and 701** -- provides a copy of the HCFA-700 and HCFA-701 forms

### **MOVED LANGUAGE**

The following language has been moved from one area of the PIM to another:

**Chapter 1, §2.2, Least Costly Alternative** -- is moved from Chapter 3 to this section.

**Chapter 1, §2.3.2, Techniques for writing LMRPs** -- is moved from Chapter 3.

**Chapter 1, §2.3.2.1, Evidence Supporting LMRPs** -- is moved from Chapter 3.

**Chapter 1, §2.3.2.2, Use of Absolute words in LMRP** -- is moved from Chapter 3.

**Chapter 1, §2.3.2.3, LMRP Requirements That Alternative Services Be Tried First** -- is moved from Chapter 3.

**Chapter 1, §2.3.5, LMRP Comment Process** -- is moved from Chapter 3.

**Chapter 1, §2.3.6, LMRP notice process** -- is moved from Chapter 3.

**Chapter 1, §2.3.7, LMRP Format** -- is moved from Chapter 3.

**Chapter 1, §2.5, Utilization Guidelines and Edit Parameters** is moved from Chapter 3.

**Chapter 1, §2.7, The Carrier Advisory Committee (CAC); §2.7.1, CAC; §2.7.2, Purpose of CAC; §2.7.3, Membership of CAC; §2.7.4, Role of CAC member; §2.7.5, CAC Structure; §2.7.6, CAC Process; §2.7.7, DMERC Advisory Panel -- is moved from Chapter 3.**

**Chapter 1, Section titled “Definitions”** has been moved to exhibit 1.

**Chapter 1, Section titled “Contractor Medical Director (CMD)”** has been moved to §6.

**Chapter 1, Section titled “Other Contractor Fraud and Abuse Requirements”** has been moved to Exhibit 2.

**Chapter 1, Section titled “Request for Information From Outside Organizations”** has been moved to Exhibit 2.

**Chapter 1, Section titled “MOU Regarding Requests from FBI/DOJ”** has been moved to Exhibit 2.

**Chapter 1, Section titled “Reporting Requirements”** has been moved to Exhibit 2.

**Chapter 1, Section titled “Periodic Exchange of Information Among OIG/FBI/DOJ/Attorneys/Medicare Contractors”** has been moved to Exhibit 2.

**Chapter 1, Section titled “Contractor Coordination with Other Entities”** has been moved to §7.2.1.

**Chapter 1, Section titled “Beneficiary, Provider, Outreach Activities”** has been moved to §7.3 and references to National Fraud and Abuse Outreach Clearinghouse have been deleted.

**Chapter 1, Section titled “Provider Education and Training (PET)”** has been moved to §5.

**Chapter 1, Section titled “MIP-PET Activities”** has been moved to §5.1.

**Chapter 1, Section titled “Focused Medical Review (FMR)”** has been deleted.

**Chapter 1, Section titled “Contractor FMR Requirements”** has been deleted.

**Chapter 1, Section titled “Provider Requirements”** has been deleted.

**Chapter 1, Section titled “Carrier Prepayment Review Personnel and Levels of Review”** has been incorporated into §2.6.

**Chapter 1, Section titled “Intermediary Review Personnel”** has been incorporated into §2.6.

**Chapter 2, §1, Reliable Information -- is moved to exhibit 4.**

**Chapter 2, §3. 6, Incentive Reward Program -- is moved from §6.**

**Chapter 2, §3.6.1, IRP General Information -- is moved from §6.1.**

**Chapter 2, §3.6.2, Information Eligible for Reward -- is moved from §6.2.**

**Chapter 2, §3.6.3, Persons Eligible to Receive a Reward** -- is moved from §6.3.

**Chapter 2, §3.6.4, Excluded Individuals** -- is moved from §6.4.

**Chapter 2, §3.6.5, Amount and Payment of Reward** -- is moved from §6.5.

**Chapter 2, §3.6.6, Contractor Responsibilities** -- is moved from §6.6.

**Chapter 2, §3.6.6.1, Guidelines for Processing Incoming Complaints** -- is moved from §6.6.1.

**Chapter 2, §3.6.6.2, Guidelines for Complaint Tracking** -- is moved from §6.6.2.

**Chapter 2, §3.6.6.3, Referral to OIG** -- is moved from §6.6.3.

**Chapter 2, §3.6.6.4, Overpayment Recovery** -- is moved from §6.6.4.

**Chapter 2, §3.6.6.5, Eligibility Notification** -- is moved from § 6.6.5.

**Chapter 2, § 3.6.6.6, Incentive Reward Payment** -- is moved from §6.6.6.

**Chapter 2, §3.6.6.7, Reward Payment audit Trail** -- is moved from §6.6.7.

**Chapter 2, §3.6.7, HCFA Incentive Reward Winframe Database** -- is moved from §6.7.

**Chapter 2, §3.6.8, Updating the Incentive Reward Database** -- is moved from §6.8.

**Chapter 2, §6** – Section titled “**Exhibits**” has been moved to Exhibit 5.

**Chapter 2, Section titled “Exhibit I – Background Information for Contractor Staff When IRP is Questioned”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Exhibit II – Reward Eligibility Notification Letter”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Exhibit III – Reward Claim Form”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Exhibit IV – How to Use the IRP Tracking System”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Section I – Pending Case List Screen”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Section II – Pending Case List by Contractor Screen”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Section III – New Case”** -- is moved to Exhibit 5.

**Chapter 2, Section titled “Section IV – Closed Case List”** -- is moved to Exhibit 5.

**Chapter 2**, Section titled “**Section V – Closed Case List by Contractor**” -- is moved to Exhibit 5.

**Chapter 2**, Section titled “**Section VI – Report Menu**” -- is moved to Exhibit 5.

**Chapter 2**, Section titled “**Verify a Problem Exists**” -- is moved to Chapter 3, §2 and has been revised.

**Chapter 2**, Section titled “**Select and Prioritize Aberrancies**” -- is moved to Chapter 3, §2 and has been revised.

### **Chapter 3**

**Chapter 3, §3 – Provider Education** -- is moved from §2 and has been revised.

**Chapter 3, §3.1 – Provider Contacts by the Fraud Unit** -- is moved from §2.1.

**Chapter 3, §8** -- Section titled “**Intermediary LMRP Format**” -- is moved to exhibit 6.

**Chapter 3, §8** --Section titled “**Carrier LMRP Format**” -- is moved to exhibit 6.

**Chapter 3, §8** --Section titled “**Physicians**” -- is moved to exhibit 3.

**Chapter 3, §8** --Section titled “**Clinical Laboratory Representative**” -- is moved to exhibit 3.

**Chapter 3, §8** --Section titled “**Beneficiaries**” -- is moved to exhibit 3.

**Chapter 3, §8** --Section titled “**Other Organizations**” -- is moved to exhibit 3.

**Chapter 3, §8** --Section titled “**Effect of Sections 1879 and 1870 of the Social Security Act**” -- is moved to exhibit 8.

**Chapter 3, §8** --Section titled “**Projection Methodologies and Instructions for Review of HHAs**” -- is moved to exhibit 9.

**Chapter 3, §8** --Section titled “**Projection Methodologies and Instructions for Review of SNFs**” -- is moved to exhibit 10.

**Chapter 3, §8** --Section titled “**Projection Methodologies and Instructions for Reviews of CORFs**” -- is moved to exhibit 11.

**Chapter 3, §8** --Section titled “**Projection Methodologies and Instructions for Reviews of CMHCs**” -- is moved to exhibit 12.

**Chapter 3, §8** --Section titled “**CMR Corrective Actions**” -- is moved to exhibit 13.

**Chapter 3, §8** --Section titled “**Contractor Denials Based on Section 1862(a)(1) of the Act**” -- is moved to exhibit 14.

**Chapter 3, §8** --Section titled “**Section 1879 Determination – Limitation of Liability**” -- is moved to exhibit 14.

**Chapter 3, §8** --Section titled “**Section 1879 Determination – Waiver of Recovery of an Overpayment**” -- is moved to exhibit 14.

**Chapter 3, §8** --Section titled “**Section 1842(l) Determination – Refunds**” to beneficiary -- is moved to exhibit 14.

**Chapter 3, §8** --Section titled “**Section titled “Consent Settlement Documents**” -- is moved to exhibit 15.

**Chapter 3, §8** --Section titled “**Model Suspension of Payment Letters**” -- is moved to exhibit 16.

**Chapter 3, §8** --Section titled “**Letter Number 1: Notice Concurrent with Effective Date of Suspension, Reason Number 1, Suspected Overpayment**” -- is moved to exhibit 16.

**Chapter 3, §8** --Section titled “**Letter Number 2: Notice Prior to Suspension, Reason Number 2, Fraud or Willful Misrepresentation**” -- is moved to exhibit 16.

**Chapter 3, §8** --Section titled “**Letter Number 3: Notice Prior to Suspension, Reason Number 3, Incorrect Payment**” -- is moved to exhibit 16.

**Chapter 3, §8** --Section titled “**Letter Number 4: Notice Prior to Suspension, Reason Number 4, Failure to Furnish Information**” -- is moved to exhibit 16.

**Chapter 3, §8** --Section titled “**Case Referral Fact Sheet Format**” -- is moved to exhibit 16.

**Chapter 3, §8** --Section titled “**Case Summary Format**” -- is moved to exhibit 16.

**Exhibit 1** --Definitions -- is moved from Chapter 1, §1.1.

**Exhibit 2** -- This exhibit -- is moved from §5 of Chapter 1.

**Exhibit 3** -- This exhibit -- is moved from §3 of Chapter 1.

**Exhibit 5** -- This exhibit -- is moved from §6 of Chapter 2.

**Exhibit 6** -- This exhibit -- is moved from §§3.2.5 and 3.2.6 of Chapter 3 and combines intermediary and carrier formats for LMRP.

**Exhibit 8** -- This exhibit -- is moved from §5.3.4 of Chapter 3.

**Exhibit 9** -- This exhibit -- is moved from §5.3.7 of Chapter 3.

**Exhibit 10** -- This exhibit -- is moved from §5.3.8 of Chapter 3.

**Exhibit 11** -- This exhibit -- is moved from §5.3.9 of Chapter 3.

**Exhibit 12** -- This exhibit -- is moved from §5.3.10 of Chapter 3.

**Exhibit 13** -- This exhibit -- is moved from §5.4.3 of Chapter 3.

**Exhibit 14** -- This exhibit -- is moved from §§6.4, 6.5, 6.6, and 6.7 of Chapter 3.

**Exhibit 15** -- This exhibit -- is moved from §7.3.3.D of Chapter 3.

**Exhibit 16** -- This exhibit -- is moved from §§8.5, 8.5.1, 8.5.2, 8.5.3, 8.5.4, 9.1.4.1, and 9.1.4.2 of Chapter 3.

**Exhibit 17** -- This exhibit was originally exhibit 1.

**Exhibit 18** -- This exhibit was originally exhibit 2.

**Exhibit 19** -- This exhibit was originally exhibit 3.

**Exhibit 20** -- This exhibit was originally exhibit 4.

**Exhibit 21** -- This exhibit was originally exhibit 5.

**Exhibit 22** -- This exhibit was originally exhibit 6.

### **DELETED LANGUAGE**

The following language has been deleted from the PIM:

**Chapter 2, §2.4.1** -- reference to Ratio I Report and Ratio II Report -- is deleted.

**Chapter 2, §6** -- Subsection titled “**Carrier Review**” -- is deleted.

**Chapter 3, §1** -- Introduction has been changed and examples of corrective actions -- is deleted.

**Chapter 3, §8** -- Section titled “**Development of MR Policy**” -- is deleted.

**Chapter 3, §8** -- Section titled “**LMRP**” -- is deleted.

**Chapter 3, §8** -- Section titled “**LMRP Notice Process**” -- is deleted.

**Chapter 3, §8** -- Section titled “**Guidelines to Determine the Proper Notice Process for Carrier LMRPs**” -- is deleted.

**Chapter 3, §8** -- Section titled “**Application of LMRP**” -- is deleted.

**Chapter 3, §8** -- Section titled “**Utilization Guidelines and Edit Parameters**” -- is deleted.

**Chapter 3, §8** -- Section titled “**Referrals between MR and Fraud and Abuse**” -- is deleted.

**Chapter 3, §8** -- Section titled “**Types of Prepayment Review**” -- is deleted.

**Chapter 3, §8** -- Section titled **“Comprehensive Post Payment Medical Review”** -- is deleted.

**Chapter 3, §8** -- Section titled **“Intermediary Selection of Providers for Comprehensive Medical Review”** -- is deleted.

**Chapter 3, §8** -- Section titled **“Intermediary procedures for provider on-site CMRs (Type 1)”** -- is deleted.

**Chapter 3, §8** -- Section titled **“Intermediary CMR Procedures Using Statistical Sampling for Overpayment Estimation (Type 2)”** -- is deleted.

**Chapter 3, §8** -- Section titled **“Select Period to be Reviewed and Composition of Universe”** -- is deleted.

**Chapter 3, §8** -- Section titled **“Select Sample Design and Claims to Include”** has been deleted.

**Chapter 3, §8** -- Section titled **“Document Universe and Frame”** has been deleted.

**Chapter 3, §8** -- Section titled **“Actions After Provider and Sample Have Been Selected”** has been deleted.

**Chapter 3, §8** -- Section titled **“File Compilation and Provider Notification of the CMR”** has been deleted.

**Chapter 3, §8** -- Section titled **“Onsite and In-house Reviews”** has been deleted.

**Chapter 3, §8** -- Section titled **“Re-adjudication and Documentation of Claims”** has been deleted.

**Chapter 3, §8** -- Section titled **“CMR Corrective Actions”** has been deleted.

**Chapter 3, §8** -- Section titled **“Estimate of the Correct Payment Amount and Subsequent Over/Underpayment”** has been deleted.

**Chapter 3, §8** -- Section titled **“Final Notification of the CMR Results/Demand Letter”** has been deleted.

**Chapter 3, §8** -- Section titled **“Recovery of Overpayment and Corrective Actions”** has been deleted.

**Chapter 3, §8** -- Section titled **“Administrative and Judicial Appeal Rights”** has been deleted.

**Chapter 3, §8** -- Section titled **“Effect of Pending Appeals on Recovery of Overpayments”** has been deleted.

**Chapter 3, §8** -- Section titled **“Changes Resulting from Provider Appeals”** has been deleted.

**Chapter 3, §8** -- Section titled **“Cost Report Appeal Issues”** has been deleted.

**Chapter 3, §8** -- Section titled “**Carrier CMR Procedures**” has been deleted.

**Chapter 3, §8** -- Section titled “**CMR Case Selection**” has been deleted.

**Chapter 3, §8** -- Section titled “**Conducting the CMR**” has been deleted.

**Chapter 3, §8** -- Section titled “**Contractor Denials**” has been deleted.

**Chapter 3, §8** -- Section titled “**Denial of Payment to an Excluded Party**” has been deleted.

**Chapter 3, §8** -- Section titled “**Denial of Payment to Beneficiaries and Others**” has been deleted.

**Chapter 3, §8** -- Section titled “**Bill/Claim Denial Documentation**” has been deleted.

**Chapter 3, §8** -- Section titled “**Appeal of Denials**” has been deleted.

**Chapter 3, §8** -- Section titled “**Reversed Denials Pending Further Action by Law Enforcement**” has been deleted.

**Chapter 3, §8** -- Section titled “**Definitions**” has been deleted.

**Chapter 5, §6.1** – Initial Certifications has been deleted.

**Chapter 5, §6.1.1** – MR has been deleted.

**Chapter 5, §6.1.2** – Items Requiring special Attention has been deleted.

**Chapter 5, §6.2** - Revised Certifications has been deleted.

**Chapter 5, §6.3** – Scheduling and Documenting Re-certifications of Medical Necessity for Oxygen has been deleted.

**Chapter 5, §6.3.1** – First Re-certification Required at 3 Months has been deleted.

**Chapter 5, §6.3.2** – First Re-certification for Long-Term Therapy has been deleted.

**Chapter 7, §6.2.2** – D-- Exhibit of Screen 6 has been deleted.

**Chapter 7, §6.2.2** – E-- Exhibit of Screen 7 has been deleted.

**Chapter 7, §7** – B--Exhibit of FMR Activity Report has been deleted.

**Chapter 7, §8.2.1.1** – Part A, Screen 1 has been deleted.

**Chapter 7, §8.2.1.2** – Part A, Screen 2 has been deleted.

**Chapter 7, §8.2.1.3** – Part A, Screen 3 has been deleted.

**Chapter 7, §8.2.1.4** – Part A, Screen 4 has been deleted.

**Chapter 7, §8.2.1.5** – Part A, Screen 5 has been deleted.

**Chapter 7, §9** – Data from automated System has been deleted consequently, the following sections were renumbered.

**Chapter 9, §2.2** – references to section 3908.5 of MIM have been deleted.

**Chapter 9, §2.4** – reference to section 3908.2C of MIM has been deleted.

**These instructions should be implemented within your current operating budget.**

# Medicare Program Integrity Manual

## {tc \14 "MEDICARE PROGRAM INTEGRITY MANUAL}

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### **Table of Contents**

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# Medicare Program Integrity Manual

## Chapter 1 - Overview of Medical Review (MR) and Benefit Integrity (BI) and Medicare Integrity Program-Provider Education and Training (MIP-PET) Programs

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## **1 – Introduction{tc "1 – Introduction" }**

The Program Integrity Manual (PIM) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of PI is to pay claims correctly. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Health Care Financing Administration (HCFA) follows four parallel strategies in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and data analysis; 3) close coordination with partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

The PIM also supports the Government Performance Results Act (GPRA) and the National Performance Review (NPR). The GPRA requires that contractors reduce the error rate identified in the Chief Financial Office's (CFO) audit. Both the GPRA and NPR instruct contractors to increase the effectiveness and improve the efficiency of medical review.

The PIM forms the basis of the Contractor Performance Evaluation (CPE) for MR and fraud units. The CPE core standards support HCFA's PI strategy. HCFA's national objectives and goals for CPE are as follows: 1) Increase the effectiveness of medical review payment safeguard activities; 2) Exercise accurate and defensible decision making on medical reviews; 3) Effectively educate and communicate with the provider and supplier community; and 4) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse.

Both MR and the fraud unit use data analysis, the foundation for detection of potential errors. The results of development situations identified by data analysis determine whether a situation is an error, which is pursued by the MR unit or potentially fraudulent which, is pursued by the fraud unit, or neither.

The purpose of this chapter is to identify the coordinated activities and differences in the purpose, functions, and requirements of the MR and fraud units. As each unit functions according to its respective procedures, close ongoing coordination is essential to support a collaborative effort in identifying unacceptable provider behaviors.

### **1.1 – Definitions{tc "1.1 – Definitions" \l 2 }**

To facilitate understanding, the terms used in the PIM are defined in Exhibit 1.

### **1.2 – Types of Claims for which Contractors are Responsible{tc "1.2 – Types of Claims for which Contractors are Responsible" \l 2 }**

Contractors are responsible for performing MR functions for the following types of claims:

- All claims appropriately submitted to a carrier, DMERC, or Regional Home Health Intermediary (RHHI) and;
- All claims appropriately submitted to an intermediary other than inpatient hospital claims.

## 2 – The Medicare MR Program{tc "2 – The Medicare Medical Review (MR) Program"}

The statutory authority for the MR program rests in the following sections of the Social Security Act (the Act):

- Section 1833(e) that states “...no payments shall be made to any provider unless it has formulated such information as the Secretary may request in order to determine the amounts due such provider.....”
- Section 1842(2)(B) that requires contractors to apply "safeguards against unnecessary utilization of services furnished by providers;"
- Section 1862(a)(1)(A) that states no Medicare payment shall be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;”
- The remainder of Section 1862(a) that describes all statutory exclusions from coverage; and
- Section 1861 and 1835 that describe the Medicare benefit categories.

The regulatory authority for the MR program rests in:

- 42CFR421.100 for intermediaries;
- 42CFR421.200 for carriers; and
- 42CFR421.300 for MIP.

Potential quality of care issues are not the responsibility of the MR unit but the responsibility of the PRO, State medical board, State licensing agency, or other appropriate entity in the service area. Contractors should refer quality of care issues to them. Contractors shall inform the appropriate Regional Office (RO) and Central Office (CO) (MROperations @[hcf.gov](mailto:hcf.gov)) of any referrals.

The goal of the medical review program is to prevent, identify, and address claim errors made by providers. To achieve the goal of the MR program, contractors:

- Identify errors through analysis of data (e.g., profiling of providers, services, or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data) (PIM Chapter 2 describes these activities in further detail); and
- Take action to prevent and/or address the identified error. Errors identified will represent a continuum of intent. The actions taken by contractors can be in the form of education, LMRP development, review of selected claims and associated medical documentation on a prepayment or postpayment basis, suspension of payment, or

referral to the fraud unit for possible criminal or civil prosecution. PIM Chapter 3 describes these actions in further detail.

Most errors do not represent fraud. Most errors are not acts that were committed knowingly, willfully, and intentionally. However, in situations where a provider has repeatedly submitted claims that have been denied, the MR unit should refer the case to the fraud unit.

Examples of errors include, but are not limited to, the following:

- Billing for noncovered services without indicating on the claim that the services are noncovered; and
- Billing incorrectly coded services.

For example, some errors will be the result of provider misunderstanding or failure to pay adequate attention to Medicare policy. Other errors will represent calculated plans to knowingly acquire unwarranted payment. Contractors are to take action commensurate with the error made. Contractors should evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction.

Contractors must pro-actively identify errors made by providers. Contractors shall scan data for inexplicable aberrations from the expected, which may indicate that errors were made.

Contractors shall have a program in place that seeks to achieve the goal of the MR program and to assure that the Medicare program makes payments only for covered, correctly coded services. The contractor practices shall emphasize prevention of errors in order to minimize recoupment efforts.

Contractors are required to develop and document an annual MR strategy that shall include:

- Description of problems identified during the past year;
- Source of problems identified (e.g., claims data, Office of Inspector General);
- Priorities for the upcoming year;
- Methods used to determine those priorities;
- Type of corrective action taken;

Beginning in November 2000, this MR Strategy should be submitted no later than November 1 to the appropriate RO and CO ([MROperations@hcfa.gov](mailto:MROperations@hcfa.gov)).

## **2.1 – National Coverage Policy (NCP), Local Medical Review Policy (LMRP), and Individual Claim Determinations**

The primary authority for all coverage provisions and subsequent policies is the Act. Medicare policies in the form of regulations, manual issuances, and LMRPs are used to apply the

provisions of the Act. Contractors make claims decisions using these policies. There are two main types of policy: NCP and LMRP.

## **A. NCP**

NCP is developed by HCFA to define whether and under what circumstances certain services are covered. It is published in HCFA regulations, the Federal Register as a final notice, contained in a HCFA ruling, or issued as a program instruction. When new NCP is published, the contractor shall notify the provider community as soon as possible of the change and corresponding effective date (this is a PM-PET activity). This NCP shall be posted to the contractor website within calendar days. In addition, this NCP shall be included, as soon as possible in a provider bulletin. The contractor shall not solicit comments or in any way alter or revise national coverage policy.

The contractor shall interpret NCPs and apply them to individual claims.

When making individual case determinations, contractors have no authority to deviate from national policy if absolute words such as "never" or "only if" are used in the policy.

Requirements for prerequisite therapies listed in NCP (e.g., "conservative treatment has been tried, but failed") must be adhered to when making decisions to cover a service.

Providers may submit requests for new or revised NCPs to HCFA CO. Procedures are described at [www.hcfa.gov/quality/8b.htm](http://www.hcfa.gov/quality/8b.htm). Contractors may submit requests for new or revised NCPs by completing the form in PIM Exhibit 6 and submitting it to Coverage and Analysis Group, Office of Clinical Standards and Quality, Mail Stop S3-02-01, 7500 Security Boulevard, Baltimore, Maryland 21244 and providing a copy to MROperations [@hcfa.gov](mailto:hcfa.gov) and the appropriate RO. State "Request for NCP" in the subject line.

## **B. LMRP**

LMRP specifies whether a service is covered (including under what clinical circumstances it is considered to be reasonable and necessary), and correctly coded. It is an administrative and educational tool to assist providers in submitting correct claims for payment. LMRPs outline how contractors will review claims to ensure that they meet Medicare coverage requirements.

The contractor may adopt LMRPs that have been developed individually or collaboratively with other contractors. The contractor shall ensure that all LMRPs are consistent with all statutes, rulings, regulations, and national coverage, payment, and coding policies.

Contractors may include in provider bulletins, websites, and educational materials general discussion regarding practice standards, existing NCPs, and existing LMRPs. However, contractors should not publish coverage or coding requirements without going through the notice and comment process.

The contractor shall use the format specified in PIM Exhibit 6, for all LMRPs.

## **Individual Claim Determinations**

***The contractor may review claim on either a prepayment or postpayment basis, regardless of whether a NCP or LMRP exists for that service. However, automated denials cannot be made in the absence of NCP or LMRP. When making individual claim determinations, the contractor shall determine whether the service in question is covered and/or correctly coded. A service may be covered by a contractor if it meets all of the following conditions:***

- it is one of the benefit categories described in title XVIII of the Act;
- it is not excluded by title XVIII of the Act; and
- it is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

## **2.2 – Least Costly Alternative**

“Least costly alternative” is a national policy provision that must be applied by contractors when determining payment for all durable medical equipment (DME). (See Medicare Carrier Manual (MCM) §2100.2.) Contractors have the discretion to apply this principle to payment for non-DME services as well.

## **2.3 – LMRP Development Process**

The process for developing the LMRP includes developing draft LMRP based on review of medical literature and the contractor’s understanding of local practice. In addition, contractors solicit comments from the medical community. Carriers solicit comments from the CAC (See PIM Chapter 1 §2.7 for further discussion of the CAC.) DMERCs solicit comments through the DAP. Contractors respond to comments and, where appropriate, incorporate them into the final LMRP. Contractors notify providers of the LMRP effective date. (See PIM Chapter 1, §2.3.6) New LMRP may **not** be implemented retroactively.

### **2.3.1 – Identification of Services For Which an LMRP is Needed**

In general contractors shall develop LMRP for those services that have demonstrate a significant risk to the Medicare trust funds. These services include identified or potentially high dollar and/or high volume services. Contractors shall give special consideration to the development of LMRP that assures beneficiary access to care. Contractors should continue to make individual claim determinations for those services that are not addressed by an LMRP.

### **2.3.2 – Techniques for Writing LMRPs**

Contractors shall ensure that LMRP are developed for services only within their jurisdiction.

The LMRP must be clear, concise, and not restrict or conflict with national policy. If a national policy states that a given item is "covered for diagnoses/conditions A, B and C," contractors may not use that as a basis to develop LMRP to cover **only** "diagnoses/conditions A, B and C." When national policy does not exclude coverage for other diagnoses/conditions, contractors must allow for individual consideration **unless** the LMRP supports automatic denial for some or all of those other diagnoses/conditions.

When an LMRP is needed, contractors do the following:

- Contact their RO, the CMD facilitation contractor, other contractors, the local carrier or intermediary, the DMERC (if applicable), or PROs to inquire if a policy which addresses the issue in question already exists;
- Use or adapt an existing LMRP, if possible; or
- Develop a policy if no policy exists or an existing policy cannot be adapted to the specific situation.

### **2.3.2.1 – Evidence Supporting LMRP**

Contractor LMRP must be based on the strongest evidence available. The extent and quality of supporting evidence is key to defending challenges to LMRPs. The initial action in gathering evidence to support LMRP must always be a search of published scientific literature for any available evidence pertaining to the item/service in question. In order of preference, LMRPs should be based on published authoritative evidence derived from definitive randomized clinical trials or other definitive studies and general acceptance by the medical community (standard of practice), as supported by sound medical evidence based on:

- Scientific data or research studies published in peer-reviewed medical journals;
- Consensus of expert medical opinion (i.e., recognized authorities in the field); or
- Medical opinion derived from consultations with medical associations or other health care experts.

Acceptance by individual health care providers, or even a limited group of health care providers, normally does not indicate general acceptance by the medical community. Testimonials indicating such limited acceptance, and limited case studies distributed by sponsors with financial interest in the outcome, are not sufficient evidence of general acceptance by the medical community. The broad range of available evidence must be considered and its quality must be evaluated before a conclusion is reached.

LMRP, which challenges the standard of practice in a community and specifies that an item is never reasonable and necessary, must be based on sufficient evidence to convincingly refute evidence presented in support of coverage.

Less stringent evidence is needed when allowing for individual consideration or when reducing to the least costly alternative.

### **2.3.2.2 – Use of Absolute Words in LMRP**

Contractors may use phrases such as "rarely medically necessary" or "not usually medically necessary" in the proposed LMRP to describe situations where a service is considered to be, in almost all instances, not reasonable and necessary. In order to limit unsolicited documentation, clearly state what specific documentation or clinical situation would have to exist to be considered reasonable and necessary. Contractors must manually review claims submitted with documentation for services where the NCP or LMRP contains these kinds of phrases.

When strong clinical justification exists, contractors may also develop LMRP that contains absolute words such as "is never covered" or "is only covered for." When phrases with absolute words are clearly stated in LMRP, contractors are not required to make any exceptions or give individual consideration based on documentation. Contractors should create edits/parameters that are as specific and narrow as possible to separate cases that can be automatically denied from those requiring individual review.

### **2.3.2.3 – LMRP Requirements That Alternative Service Be Tried First**

Contractors may incorporate into LMRP the concept that use of an alternative item or service precedes the use of another item/service. This approach is termed a "prerequisite." Contractors must base any requirement on evidence that a particular alternative is more safe, more effective, or more appropriate for a given condition without exceeding the patients' medical needs. Prerequisites must be based on medical appropriateness, not on cost effectiveness. Non-covered items (e.g., pillows to elevate feet) may be listed. Any prerequisite for drug therapy must be consistent with national coverage policy for labeled uses. Whenever national policy bases coverage on an assessment of need by the beneficiary's provider, prerequisites should not be included in LMRP. As an alternative, contractors may use phrases in the proposed LMRP like "the provider should consider..."

### **2.3.3 – Coverage Provisions in LMRPs**

A service may be covered by a contractor if it meets all of the following conditions:

- It is one of the benefit categories described in title XVIII of the Act;
- It is not excluded by title XVIII of the Act; and
- It is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

#### **A– Benefit Category**

In order to be covered under Medicare, a service must be one of the benefits described in title XVIII of the Act and it meets the definition of that benefit category listed in HCFA's Manual, e.g., (See MIM, §§3101ff).

## **B – Service Statutorily Excluded on Grounds Other Than Section 1862(a)(1)(A)**

In order to be covered under Medicare, a service must not be excluded by title XVIII of the Act, **other than** by §1862(a)(1)(A). Such exclusions include, but are not limited to, routine physical checkups, immunizations, cosmetic surgery, hearing aids, eyeglasses, routine foot care, and most dental care.

There are statutory exceptions to these exclusions that are specified or cross-referenced in the full text of §1862(a) for the following items and services:

- Pneumococcal, influenza and hepatitis B vaccines are covered if they are reasonable and necessary for the prevention of illness;
- Hospice care is covered if it is reasonable and necessary for the palliation or management of terminal illness;
- Screening mammography is covered if it is within frequency limits and meets quality standards;
- Screening pap smears and screening pelvic exam are covered if they are within frequency limits;
- Prostate cancer screening tests are covered if within frequency limits;
- Colorectal cancer screening tests are covered if within frequency limits; and
- One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens.

## **C – Reasonable and Necessary**

In order to be covered under Medicare, a service must be reasonable and necessary. When appropriate, describe the circumstances under which the proposed LMRP for the service is considered. The proposed LMRP should describe when a service is considered

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  - Furnished in a setting appropriate to the patient's medical needs and condition;
  - Ordered and/or furnished by qualified personnel;
  - One that meets, but does not exceed, the patient's medical need; and
  - At least as beneficial as an existing and available medically appropriate alternative.

### **2.3.4 – Coding Rules in LMRPs**

In its LMRP, a contractor may describe the national and/or local coding rules that pertain to this service.

### **2.3.5 – LMRP Comment Process**

When developing LMRP, the contractor must solicit comments and recommendations on the policy and get input from the medical community, from **at least**:

- Appropriate groups of health professionals and provider organizations that may be affected by the LMRP;
- Other intermediaries/carriers;
- PROs within the region; and
- Other CMDs within the region.

In addition, carriers obtain input from:

- The CAC; and
- The DAP.

## **A – Additional LMRP Distribution Responsibilities**

Distribution of LMRPs proposed by carriers for comment is not restricted to members of the CAC. Additional distribution to providers of service or representatives of specialty societies and organizations (carriers should consult other than those represented in the committee) should take place when appropriate (e.g., efforts should be made to ensure that providers who have a history of billing for the service are informed of the proposed LMRP and have the opportunity to comment). Carriers should present data according to the procedures for submitting data to the CAC. (PIM Chapter 1, §2.7.6B)

Draft LMRPs should also be sent to the RO, Associate Regional Administrator, for distribution to the appropriate regional staff (e.g., coverage experts, reimbursement experts). The RO staff will review the LMRPs for any operational concerns.

Contractors must remain sensitive to other organizations or groups which may have an interest in an issue (e.g., laboratories, providers who provide services in nursing facilities, home care, or hospice and the associations which represent the facilities/agencies) and invite them to participate in meetings at which a related LMRP is to be specifically discussed.

## **B – LMRP Comment Period and Responses**

Contractors must provide a minimum comment period of 45 days. Carriers begin the comment period at the time the policy is distributed to the CAC either at the regularly scheduled meeting or in writing to all members of the CAC. For intermediaries, the comment period begins when the policy is distributed to medical providers or organizations. Contractors must incorporate all comments into the LMRP as appropriate. Depending on the nature of comments received, the contractor must decide whether to provide a general response through a provider newsletter and/or individual written responses.

### **2.3.6 – LMRP Notice Process**

Contractors must make final LMRPs public via a special bulletin, update to a provider manual, or inclusion in a newsletter, and through their website. Contractors submit final policy notices to all Medicare contracting health maintenance organizations and competitive medical plans (i.e., risk, cost, and health care prepayment plans) and the RO. Contractors must ensure that the effective date for LMRPs follow a minimum notice period of 30 days. (For DMERCs, the notice period is 45 days.) Contractors must educate the provider community on new or revised LMRPs (e.g., training sessions, speaking at society meetings or writing articles in the society's newsletter). To enhance consistency in LMRP, contractors must share LMRP bulletins with other CMDs. Carriers are required to publish DMERC summary policies, and other pertinent information supplied by DMERCs, as requested, as part of regular bulletin distributions.

Apply the following guidelines in determining the proper LMRP notice and comment process for certain situations.

## **A – Substantive Changes**

- Restricting Existing LMRP

When a revision to a policy restricts an existing LMRP, the entire notice and comment process must be used (except as noted above).

- Liberalizing a Policy

If a revised LMRP **liberalizes** an existing LMRP, (e.g., expands the list of diagnoses for which the item/service is considered reasonable and necessary), contractors may publish the change and implement the revised policy and forego the notice and comment period.

## **B – Non-substantive Changes**

- Clarification

A policy that is clarified (i.e., merely adding information to make the policy more understandable and does not make the policy more restrictive or more liberal) is subject to the 30-day notice period. The clarification should be published in the next bulletin.

- Correction

If a policy needs to be corrected due to a simple typographical error, the policy correction should be published within 30 days. However, if there is an accidental deletion or insertion that impacts the policy's intent, the notice and/or comment period should be extended by 30 days. If the error is contained in the version for notice, contractors extend the notice period. If the error is contained in the comment period, they extend the comment period.

## **C – Situations that Allow Bypassing the Notice and Comment Process**

If a new/revised LMRP is developed and there are compelling reasons to forego the notice and comment process, **with RO approval**, (e.g., egregious abuse, a highly unsafe procedure/device, or if the HCFA has changed policy that would supersede the current policy), contractors simultaneously initiate the notice and comment period and implement the new/revised policy. This approval should be obtained prior to the time that the physician community is notified. Except when liberalizing an existing policy, RO approval must be obtained whenever the required notice and comment period is bypassed.

### **2.3.7 – LMRP Format**

Contractors shall forward draft and final LMRPs to ROs using the formats identified in PIM Exhibit 6. State “Draft LMRP for [specify service]” or “Final LMRP for [specify service]” in the Subject line. Additionally, final LMRP must be forwarded to [contractorpolicy@hcfa.gov](mailto:contractorpolicy@hcfa.gov), and [cohenj@kathpal.com](mailto:cohenj@kathpal.com).

Contractor LMRPs must be available on request to CO and the ROs in the HCFA designated word processing format.

### **2.4 – Application of LMRP**

Contractors may apply LMRPs to claims on either a prepayment or postpayment basis. If a contractor decides to enforce an LMRP on a prepayment basis, the contractor must design an MR edit. (See PIM Chapter 3, §5) Contractors have flexibility to add, alter, or eliminate MR edits at any time.

In those instances where prepayment review is fully or partially automated, the LMRP must clearly list the circumstances under which a service will be denied. Also, services that are specifically excluded by statute or that NCP states are never covered can be automatically reviewed and need not be manually reviewed before denial. When a NCP or LMRP clearly indicates that under certain circumstances a service is NEVER covered, contractors may automatically deny the services under those circumstances without stopping the claim for manual review, even if documentation is attached. Contractors must still make a liability determination that may require manual review. (See PIM Chapter 3, §6.7)

Contractors must apply LMRPs prepayment or postpayment prospectively to medical review of claims with dates of service on or after the effective date of the policy. Contractors should not apply a LMRP retroactively to claims processed prior to the effective date of the policy. However, if both LMRP and the NCP fail to address an issue of coverage for a given claim, contractors make coverage determinations based on the information provided.

## **2.5 – Utilization Guidelines and Edit Parameters**

Contractors must have clear, understandable instructions, outlining how claims are selected for review and how policy is to be applied so that staff reviewing claims make appropriate decisions.

Utilization guidelines describe the typical usage of an item or service. Utilization guidelines may be included in NCP or LMRP and may be released to the public. In contrast, a parameter is the level, often a utilization threshold, below which the contractor does not perform MR. Parameters are a workload control tool and, as such, may **not** be released to the public even under the Freedom of Information Act.

## **2.6 – Manual Review Personnel and Levels of Review**

Contractor manual review of claims involves specially trained claims examiners, licensed practical nurses, registered nurses, physicians, and other types of clinicians. Contractors must use health professionals to review all claims that are medically complex. MR personnel must be trained to review claims, apply policy, and when needed, refer claims to a more highly skilled level.

The decision to review must be part of the priority setting process, except for the following HCFA-mandated reviews:

- Review of Skilled Nursing Facility (SNF) inpatient and home health demand claims; and
- Review of rehabilitation medicine visits that exceed a HCFA established parameter (see PIM Chapter 6).

When appropriate, contractors may request and review additional medical documentation. If documentation is not normally needed, contractors should automate the review to the greatest extent possible. Medical documentation includes medical information forms or electronic records developed by HCFA or the intermediary, copies of medical record information, and any additional information required to make a coverage or coding determination.

The following levels of review represent a continuum of technical and clinical expertise.

### **A – First Level Manual Review**

First level reviewers should be trained to use internal guidelines to apply policy and make determinations (e.g., approve, deny (in full or in part), request additional information, or refer to a higher level of review). First level reviewers may not deny claims without specific, detailed, written internal guidelines. A second or higher level reviewer will handle claims which the First Level reviewer is not trained to process.

### **B – Second Level Manual Review**

Second level reviewers are more experienced than first level reviewers. Second level reviewers have proven, based on performance, their ability to make appropriate decisions, and apply guidelines and policy.

### **C – Clinician Review**

Experienced nurse reviewers and physician reviewers generally need less detailed instructions than first and second level claims reviewers. Both nurse and physician reviewers may call upon clinical expert consultants for advice. Any determination by a clinician must be documented and include the rationale for the decision. While clinicians must also follow NCP and LMRPs, they are expected to interpret ambiguous or "gray" areas not addressed by local or national policy, and when necessary, evaluate the appropriateness of the service.

## **2.7 – The Carrier Advisory Committee (CAC)**

### **2.7.1 – The CAC**

Carriers must establish one CAC per State. Where there is more than one carrier in a State, the carriers must jointly establish a CAC. If there is one carrier for many States, each State shall have a full committee and the opportunity to discuss draft LMRPs and issues presented in their State. Carriers maintain a current directory of CAC members which is available to CO, RO staff, and the provider community on request. Carriers that develop identical policies within a single region may establish a single CAC with permission from the RO. In order to obtain a waiver from the RO, contractors must obtain consensus agreement from all CAC members within the region.

### **2.7.2 – Purpose of the CAC**

The purpose of the CAC is to provide:

- A formal mechanism for physicians in the State to be informed of and participate in the development of an LMRP in an advisory capacity;
- A mechanism to discuss and improve administrative policies that are within carrier discretion; and
- A forum for information exchange between carriers and physicians.

Carriers must clearly communicate to CAC members that the focus of the CAC is LMRPs and administrative policies and not issues and policies related to private insurance business. The CAC is not a forum for peer review, discussion of individual cases or individual providers. While the CAC must review all draft LMRPs, the final implementation decision about LMRPs rests with the CMD.

The CMD jointly develops the agenda with the co-chair representing the CAC to include concerns about LMRPs and local administrative issues.

### **2.7.3 – Membership on the CAC** {tc "2.7.3 – Membership on the CAC " \l 3}

The CAC is to be composed of physicians, a beneficiary representative, and other medical organizations. Each is individually described in Exhibit 3.

### **2.7.4 – Role of CAC Members**{tc "2.7.4 – Role of CAC Members" \l 3}

CAC members serve to improve the relations and communication between Medicare and the physician community. Specifically, they:

- Disseminate proposed LMRPs to colleagues in their respective State and specialty societies to solicit comments;
- Disseminate information about the Medicare program obtained at CAC meetings to their respective State and specialty societies; and
- Discuss inconsistent or conflicting MR policies.

### **2.7.5 – CAC Structure**{tc "2.7.5 – CAC Structure" \l 3}

#### **A – Number of Representatives**

Each specialty shall have only one member and a designated alternate with approval of committee co-chairs. Additional members may attend when policies that require their expertise are under discussion. Carriers maintain a current local directory of CAC members that is available to CO, RO, or the provider community on request.

#### **B – Tenure**

Carriers have discretion to establish the duration of membership on the committee. The term should balance the duration of time needed to learn about the process to enhance the level of participation and functioning with the desire to allow a variety of physicians to participate. Consider a 2-3 year term.

## **C – Co-Chairs**

The CAC shall be co-chaired by the medical director and one physician selected by the committee. The co-chairs:

- Run the meetings and determine the agendas;
- Provide the full agenda and background material to each committee member at least 14 days in advance; and
- Encourage committee members to discuss the material and disseminate it to interested colleagues within their specialty and to clinic or hospital colleagues for whom the item may be pertinent. The members may bring comments back to the meeting or request that their colleagues send written comments to the CMD separately.

Attendance at the meeting is at the discretion of the committee members. If the item is of importance to their specialty, encourage members to attend or send an alternate. This is the primary forum for discussion of proposed LMRPs developed by the CMD. The 45-day comment process required for all LMRPs starts when the proposed LMRP is distributed to the committee members. (See PIM Chapter 1 §2.3.5).

Co-chairs present all proposed LMRPs to the CAC for discussion. If the need arises to develop and implement LMRPs before the next scheduled meeting, they solicit comments from committee members by mail or e-mail.

## **D – Staff Participation**

The Director of Medicare Operations must assure that appropriate contractor staff attend to address administrative issues on the agenda. Other staff may also be required to attend include:

- Professional relations representative;
- MR manager and
- MFIS.

## **E – Location**

Carriers work with the State medical society and committee members to select a meeting location that will optimize participation of physician committee members.

### **2.7.6 – CAC Process**

#### **A – Frequency of Meetings**

Hold a minimum of 3 meetings a year, with no more than 4 months between meetings.

## **B – Data**

Each meeting should include a discussion and presentation of comparative utilization data that has undergone preliminary analysis by the carrier and relates to discussion of proposed LMRP. Carriers solicit input from CAC members to help explain or interpret the data and give advice on how overutilization should be addressed. The use of data to illustrate the extent of problem billing (e.g., average number of services per 100 patients) may help justify the need for a particular policy. The comparative data should be presented using graphs, charts, and other visual methods of presenting data. Carriers may present egregious individual provider's data as long as the provider's identification is not disclosed or cannot be deduced.

## **C – Payment for Participation**

Participation in the CAC is considered a service to physician colleagues. Carriers do not provide an honorarium or other forms of compensation to members. Expenses are the responsibility of the individuals or the associations they represent.

## **D – Recordkeeping**

Carriers keep minutes of the meeting and distribute them to members. Carriers submit the following items from CAC meetings to the RO MR staff within 10 days following the meetings:

- A copy of the meeting agenda (include the date of the meeting);
- A prompt copy of meeting minutes (not approved);
- A copy of the approved minutes from the prior meeting, including a summary of this discussion and the number of attendees, broken down into committee members, alternates or observers and RO staff; and
- Tentative date of the next meeting.

Also, submit a copy of the approved CAC minutes to CO. Send the approved CAC minutes via email to: [MROperations@HCFA.GOV](mailto:MROperations@HCFA.GOV) State "CAC Minutes" in the subject line of the email.

## **E – Communicating With CO on National Issues**

While the CMD should encourage CAC members to work through their respective organizations and Practicing Physicians Advisory Council (PPAC) to effect national policy, the CAC is not precluded from commenting on these issues. When appropriate, the CMD may choose to forward a formal letter to CO from the CAC. Send these letters through the RO, where they will be answered or forwarded to the appropriate component in CO for response.

## **F – Support for Beneficiary Member**

Provide individual support to the beneficiary representative in understanding the CAC role and process. This includes assisting the beneficiary representative in understanding the LMRPs so they are better able to determine the effect of the policy on the beneficiary community. Carriers are encouraged to find ways to involve the beneficiary community in efforts to stem abuse through LMRP development.

### **2.7.7 – Durable Medical Equipment Regional Carrier (DMERC) Advisory Process (DAP)**

The DMERC must establish a forum of DME advisory workgroups in each region to discuss DME issues and concerns with physicians, clinicians, beneficiaries, suppliers, and manufacturers. Options for this forum may include ad hoc workgroups that are time-limited and/or topic specific. Advisory participants do not advise the Federal Government. Therefore, the rules governing open meetings of Federal Government committees do not apply to the DAP process. Encourage individuals who are concerned with the issues or processes pertaining to DME to attend.

#### **A – Purpose**

The purpose of the DAP is to provide:

- A formal mechanism to obtain input regarding Regional Medical Review Policy (RMRP) development and revision;
- A mechanism to discuss and improve administrative policies that are within the DMERCs' discretion; and
- A forum for information exchange between the DMERCs, physicians, clinicians, beneficiaries, suppliers, and manufacturers.

### **3 – The Medicare Fraud Program**

The primary goal of the fraud unit is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped. Suspension and denial of payments and the recoupment of overpayments are an example of the actions that may be taken. All cases of potential fraud are referred to the OIG, Office of Investigations Field Office (OIFO) for consideration and initiation of criminal, civil monetary penalty, or administrative sanctions actions. (See PIM Chapter 3, §§10ff, §§11ff, and §§12ff.) Contractor personnel conducting each segment of claims adjudication, MR, and professional relations functions must be aware of their responsibility for identifying fraud and be familiar with internal procedures for forwarding potential fraud cases to the fraud unit.

Preventing and detecting potential fraud involves a cooperative effort among beneficiaries, Medicare contractors, providers, PROs, State Medicaid Fraud Control Units (MFCUs), and Federal agencies such as HCFA, OIG, Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ).

Contractors must use the guidelines and suggestions in this document for preventing, detecting and developing incidents of suspected fraud.

Each investigation is unique and should be tailored to the specific circumstances. These guidelines are not to be interpreted as requiring the contractor to follow a specific course of action or establishing any specific requirements on the part of the government or its agents with respect to any investigation. Similarly, these guidelines should not be interpreted as creating any rights in favor of any person, including the subject of an investigation.

When the fraud unit has determined that a situation is not fraud, it should refer these situations to the MR unit for corrective action. (See PIM Chapter 1 §2)

### **3.1 – Examples of Medicare Fraud**

The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. The violator may be a provider, a beneficiary, or an employee of a provider or some other person or business entity, including a billing service or an intermediary employee.

Providers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, there is also a range of administrative sanctions (such as exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Fraud may take such forms as:

- Incorrect reporting of diagnoses or procedures to maximize payments;
- Billing for services not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice;
- Altering claim forms, electronic claim records, medical documentation, etc. to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate, e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment;
- Unbundling or "exploding" charges;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider;

- Participating in schemes that involve collusion between a provider and a beneficiary, or between a supplier and a provider and result in higher costs or charges to the Medicare program;
- Participating in schemes that involve collusion between a provider and a contractor employee where the claim is assigned, e.g., the provider deliberately overbills for services, and the contractor employee then generates adjustments with little or no awareness on the part of the beneficiary;
- Billing based on "gang visits," e.g., a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients;
- Misrepresentations of dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services;
- Billing non-covered or non-chargeable services as covered items;
- Repeatedly violating the participation agreement, assignment agreement, and the limitation amount;
- Using another person's Medicare card to obtain medical care;
- Giving false information about provider ownership in a clinical laboratory; and
- Using the adjustment payment process to generate fraudulent payments.

Examples of cost report fraud may include:

- Incorrectly apportioning costs on cost reports;
- Including costs of non-covered services, supplies, or equipment in allowable costs;
- Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting) to siphon off or conceal illegal profits;
- Billing Medicare for costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses;
- Repeatedly including unallowable cost items on a provider's cost report except for purposes of establishing a basis for appeal;
- Manipulation of statistics to obtain additional payment, such as increasing the square footage in the outpatient areas to maximize payment;
- Claiming bad debts without first genuinely attempting to collect payment;

- Certain hospital-based physician arrangements and amounts also improperly paid to physicians;
- Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements;
- Days that have been improperly reported and would result in an overpayment if not adjusted;
- Depreciation for assets that have been fully depreciated or sold;
- Depreciation methods not approved by Medicare;
- Interest expense for loans that have been repaid for an offset of interest income against the interest expense;
- Program data where provider program amounts cannot be supported;
- Improper allocation of costs to related organizations that have been determined to be improper; and
- Accounting manipulations.

### **3.2 – Medicare Fraud Unit**

This unit is responsible for preventing, detecting, and deterring Medicare fraud and abuse. The fraud unit:

- Prevents fraud and abuse by identifying program vulnerabilities;
- Pro-actively identifies incidents of fraud that exist within its service area and takes appropriate action on each case;
- Develops (determines factual basis) allegations of fraud made by beneficiaries, providers, HCFA, OIG, and other sources;
- Explores all available sources of fraud leads in its jurisdiction, including the MFCU and its corporate anti-fraud unit;
- Initiates appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud;
- Develops cases and refers them to the Office of Inspector General/Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions. (See PIM Chapter 3 §10ff, §11ff and §12ff.);
- Provides outreach to providers and beneficiaries; and

- Initiates and maintains networking and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups. (See Chapter 1, §3.2.5.1 and §7.2 and PIM Exhibit 2.1.2.)

### **3.2.1 – Organizational Requirements**

Organizationally, each contractor has a component responsible for the detection, development, and initiating corrective action of fraud and abuse cases. Staff supervised by a full-time unit manager conduct required fraud activities. This group is referred to as the "fraud unit". It may consist of employees who work full-time on Medicare fraud issues, employees who work part-time on Medicare and part-time on corporate-side fraud. If an employee works Medicare and corporate-side cases, contractors must take special care not to mix Medicare and corporate-side data. If workload supports a full-time unit, it must be a separate and distinct unit within the contractor organization and may not be combined with the MR and corporate-side PI units, i.e., it works only Medicare cases. Contractors that are both intermediaries and carriers may combine the fraud activities within a single unit. This includes providing electronic data processing and medical consultant support as is required for the unit to complete its mission. Multi-State contractors must maintain at least one contact at each site. Separate time records must be maintained on any part-time staff assigned to the fraud unit. Large contractors must, however, establish separate distinct fraud units. Regardless of the number of personnel in the fraud unit, all necessary action must be taken to ensure the integrity of Medicare payments. This means that an effective Medicare payment safeguard program must be in place.

The unit manager must have sufficient authority to guide PI activities. The manager must be able to establish, control, evaluate, and revise fraud detection procedures to ensure their compliance with Medicare requirements.

The unit manager must prioritize work coming into the unit to ensure that the cases with the greatest program impact are given the highest priority. Allegations or cases having the greatest program impact would include cases involving:

- Multi-State fraud;
- Patient abuse;
- High dollar amounts of potential overpayment; or
- Likelihood for an increase in the amount of fraud or enlargement of a pattern.

To ensure the integrity of fraud unit referrals to OIG/OI, referrals by the fraud unit to OIG/OI are not subject to the approval of contractor management officials.

### **3.2.2 – Liability of Fraud Unit Employees**

In the course of investigating a provider, the provider may sue the contractors. Such suits are not common, and even more rarely, successful. It should be noted that courts, over the past several years, have begun sanctioning attorneys for filing frivolous complaints. As agents of the Federal

Government, the courts have generally agreed that contractors have what is referred to as official immunity.

The doctrine of official immunity provides that government officials enjoy an absolute privilege from civil liability should the activity in question fall within the scope of their authority and if the action undertaken requires the exercise of discretion. Moreover, contractors are assured an offer of a defense by the U.S. Attorney's office as long as the contractors were performing activities required by HCFA and within the scope of the job description. Contractors are protected even if the contractors make honest mistakes or errors of judgment.

Contractors are not protected if the contractors go beyond their authority or scope of activities or commit torts or criminal acts (e.g., trespass or libel). Contractors are subject to risk if the contractors act with malice or vindictiveness.

Investigating fraud and prosecuting offenders falls well within the Government's interests and whatever resources are needed will be used to protect contractors and those activities. Sections 1816(i) and 1842(e) of the Act are the authorities that HCFA has construed to provide a basis for Medicare contractors' entitlement to indemnification for litigation costs and adverse judgements that are incurred as a consequence of performing the claims payment portion of their official duties. This includes fraud and abuse activities.

When contractors are served with a complaint, they should immediately contact the corporate general counsel. Contractors forward the complaint to the Health and Human Services Office of the Regional Chief Counsel (HCFA Regional Attorney) who, in turn, will notify the U.S. Attorney. The HHS Office forwards the complaint to the U.S. Attorney within 20 calendar days of receipt.

### **3.2.3 – Anti-Fraud Training**

All levels of employees must be acquainted with the goals and techniques of fraud detection and control (i.e., general orientation for new employees, and highly technical sessions for fraud unit staff, claims processing, medical review, audit, and appeals). Training materials must be consistent with current HCFA procedural requirements. The RO must approve, in advance, training from outside sources that provide information on the contractor's Medicare fraud mission.

The MFIS assigned to the contractor jurisdiction should notify contractors of training programs planned at other contractors in the area that staff may attend.

All fraud unit personnel, excluding clerical staff, receive specialized training from OIG and HCFA. Training requirements prescribed by HCFA must be met. Required training for each year is specified in the budget and performance requirements or special instructions issued through the RO.

#### **3.2.3.1 – Training for Law Enforcement Organizations**

FBI agents and DOJ attorneys need to understand Medicare. Contractors should conduct special training programs for them. Contractors should consider inviting DOJ, attorneys, and FBI agents

to existing programs intended to orient employees to carrier or intermediary operations or to get briefings on specific cases or Medicare issues.

### **3.2.4 – Procedural Requirements**

Contractors must provide written procedures for fraud unit personnel and for personnel in other contractor components (claims processing, MR, beneficiary services, intermediary audit, etc.) to help identify potential fraud situations. Include provisions to ensure that personnel:

- Refer potential fraud cases promptly to the fraud unit;
- Forward complaints alleging fraud to the fraud unit;
- Maintain confidentiality of referrals to the fraud unit so that the civil rights of those involved are protected ; and
- Forward to the fraud unit documentation of the details of telephone or personal contacts involving fraud issues discussed with providers or provider staff.

In addition, the fraud unit must have written procedures for personnel to:

- Keep educational/warning correspondence with providers and other fraud documentation concerning specific issues in individual provider files for 7 years, so that contractors are able to retrieve such documentation easily;
- Maintain communication and information flowing between the fraud, MR, and intermediary audit staffs;
- Take appropriate action on cases not accepted by OIG. Assure MR staff is immediately notified regarding OIG's decision. At a minimum, provide for recovery of identified overpayments and other corrective actions discussed in PIM Chapter 3, §§8ff, §§9ff, §§10ff and §11ff.
- Properly prepare and document cases referred to OIG/OI; (See PIM Exhibits 16.1 and 16.2 for details.)
- Furnish all available information to OIG/OI with respect to providers requesting reinstatement;
- Ensure no payments are made for services ordered, referred, or furnished by an individual or entity following the effective date of exclusion (see PIM Chapter 3, §11 for exceptions);
- Ensure all instances where an excluded individual or entity that submits claims for which payment may not be made after the effective date of the exclusion are reported. (see PIM Chapter 3 §11.);
- Ensure no payments are made for an excluded individual or entity who is employed by a Medicare provider or supplier;

- Ensure all cases where a provider consistently fails to comply with the provisions of the assignment agreement are reported to the RO;
- Maintain documentation on the number of complaints alleging fraud or abuse, cases referred to OIG/OI (and the disposition of those cases), processing time of complaints, and types of violations referred to OIG (e.g., item or service not received, unbundling, waiver of co-payment); and
- Conduct reviews (including procedures for reviewing questionable billing codes), make beneficiary contacts, (see PIM Chapter 2 §3.4 for details concerning reviews) and referral of cases to and from the MR unit.

### **3.2.4.1 – Maintain Controlled Filing System and Documentation**

Contractors maintain files on providers who have been the subject of complaints, prepayment flagging, fraud unit investigations, OIG/OI investigations, U.S. Attorney prosecution and any other civil, criminal or administrative action for violations of the Medicare or Medicaid program. The files should contain documented warnings and educational contacts by the MR unit, the results of previous investigations, and copies of complaints.

Contractors must set up a system for assigning and controlling numbers at the initiation of case development and ensure that:

- All incoming correspondence or other documentation associated with a case contains the same file number and is placed in a folder containing the original case material;
- Case files are adequately documented to provide an accurate and complete picture of the investigative effort;
- All contacts are clearly and appropriately documented; and
- Each case file lists the name, organization, address and telephone numbers of all persons with whom the contractor can discuss the case (including those working within the fraud unit).

It is important to establish and maintain histories and documentation on all fraud and abuse cases. Contractors conduct periodic reviews of the kinds of fraud detected over the past several months to identify any patterns of potential fraud and abuse situations for particular providers. The contractors ensure that all evidentiary documents are kept free of annotations, underlining, bracketing, or other emphasizing pencil, pen, or similar marks.

Contractors must establish an internal monitoring and case review system to ensure the adequacy and timeliness of fraud and abuse activities.

### **3.2.5 – Medicare Fraud Information Specialist (MFIS)**

The MFIS position is to be 100 percent dedicated to the MFIS activities described below, unless CO and the applicable RO approves otherwise. The MFISs' primary responsibility is to share information concerning fraud with ROs, contractors in their jurisdiction, other MFISs, law enforcement agencies, State agencies, and other interested organizations (e.g., Ombudsmen, Administration on Aging (AoA), Harkin Grantees and other grantee recipients) for both Part A and Part B of the Medicare program. The MFISs are not fraud investigators. Without RO and CO concurrence, the MFISs are not to perform functions such as complaint resolution, case development, clearinghouse functions, OIG hotline referrals, fraud investigation database (FID) entries, data analysis, incentive reward program (IRP) entries, and onsite audits.

The MFISs are Medicare contractor employees. As such, they report directly to the contractor's BI unit manager or BI unit director equivalent. The MFISs' jurisdiction will correspond to their RO's jurisdiction; it is not to cross over RO boundaries, other than when needed on an exception basis. The ROs in coordination with the CO will promptly determine the contractor that will employ each MFIS whenever an MFIS terminates their employment with the contractor or a contractor leaves the Medicare program. The jurisdictions break down according to the following ROs and the number of MFIS required for each region:

<u>Regional Office</u>	<u>Number of MFIS</u>
I Boston	1
II New York	1 1/2 (1/2 is Puerto Rico)
III Philadelphia	1
IV Atlanta	3 (1 solely dedicated to Florida)
IV RHHI	2
V Chicago	2
VI Dallas	1
VII Kansas City	1
VIII Denver	1
IX San Francisco	2
X Seattle	1
X DMERC	1

The designated MFISs in each region will be responsible for both Part A and Part B of the Medicare program with the exception of the DMERC and RHHI MFISs.

The DMERC MFIS position will report to Region X, and is responsible for informing other ROs of schemes, cases and/or investigations affecting those regions.

There will be two RHHI MFIS who will report to Region IV, and they are currently located at United Government Services (UGS) in Wisconsin and Palmetto Government Benefits Administrators (PGBA) in South Carolina. The UGS RHHI MFIS will be responsible for the following: Alaska, Arizona, California, Colorado, Delaware, District of Columbia, Hawaii, Idaho, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Puerto Rico, South Dakota, U.S. Virgin Islands, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. The PGBA RHHI MFIS will be responsible for the following: Alabama, American Samoa, Arkansas, Connecticut, Florida, Georgia, Guam, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma,

Rhode Island, South Carolina, Tennessee, Texas, and Vermont. The RHHI MFIS is also responsible for informing other ROs of schemes, cases, and/or investigations affecting those regions.

All contractors regardless of where the MFIS is located must communicate with their assigned MFIS and utilize his/her services. The major duties and responsibilities listed below should be performed by the MFIS equally for all contractors within their jurisdiction.

MFISs are to submit monthly reports to the RO. These reports should quantify activities wherever possible. At a minimum, the reports should include the information listed below:

1. Networking activities such as meetings attended and conference calls with the following information:
  - a) Identity of the meetings and the speakers;
  - b) Dates of the meeting;
  - c) Location of the meetings;
  - d) How many meetings were attended;
  - e) Number of attendees for each meeting; and
  - f) The results of each meeting.
2. Outreach/training activities (e.g., HCFA health care partner interaction) with the following information:
  - a) Identity of the outreach/training;
  - b) Dates of the outreach/training;
  - c) Location of the outreach/training;
  - d) The number of training/outreach sessions conducted; and
  - e) The number of attendees for each session.
3. Planned events (e.g., calendar of upcoming months).
4. Alerts (HCFA, OIG, MFIS) to include those authored by the MFIS in addition to those not authored by the MFIS but distributed by them.
5. Special projects (e.g., significant activities not included in the above).

### **3.2.5.1 - MFIS Position Description**

#### Major Duties and Responsibilities of the Medicare Fraud Information Specialist:

- Obtains and shares information on health care issues/fraud investigations among fellow MFISs, carriers (including DMERC), intermediaries (including RHHI), HCFA and law enforcement.
- Serves as a reference point for law enforcement and other organizations and agencies to contact when they need help or information on Medicare fraud issues and don't know whom to contact.

- Assists contractors, HCFA RO, law enforcement, HCFA health care partners by coordinating and attending fraud related meetings/conferences and informs all appropriate parties about these meetings/conferences. These meetings/conferences include but are not limited to, health care task force meetings, MFIS meetings (in-person/annual meetings) and MFIS conference calls. The MFIS is to relay all pertinent information from these meetings/conferences to the fraud managers within the MFIS' jurisdiction and applicable HCFA ROs as appropriate.
- Distributes all fraud alerts to the appropriate parties within their jurisdiction. Shares contractor findings on fraud alerts with contractors in their jurisdiction, fellow MFISs, and HCFA.
- Works with the HCFA RO to develop and organize external programs and perform training as appropriate for law enforcement, ombudsmen, grantees (e.g., Harkin Grantees) and other HCFA health care partners (e.g., AoA, State Medicaid Fraud Control Unit).
- Conducts regular calls/visits with the fraud unit managers within the MFIS' Jurisdiction to address their needs.
- Serves as a resource to HCFA as necessary. For example, serves as a resource to HCFA on the FID, including FID training. While the MFIS should not enter cases into the FID or monitor FID quality, if the MFIS detects any inaccuracies or discrepancies they should notify the contractor. Upon request, the MFIS will furnish FID reports to the fraud unit managers within their jurisdiction.
- Helps develop fraud related outreach materials (e.g., pamphlets, brochures, videos, etc.) in cooperation with contractors' beneficiary services and/or provider relations departments to use in their training. Submits written outreach materials to the HCFA RO for clearance. Ensures these materials are incorporated into the contractors' existing outreach efforts. Conducts high level, fraud specific presentations/training.
- Assists in preparation and development of fraud related articles for contractor newsletters/bulletins for all contractors within the MFIS' jurisdiction.
- Serves as a resource for the development of annual internal and new hire fraud training. (The BI unit contractor staff is responsible for performing the actual fraud training.)
- Attends 32 hours of training sessions on training skills, presentation skills (16 hours) and fraud related training (16 hours) the first year of employment and every 3 years thereafter. Current MFISs would also be required to meet these training requirements during FY 2001, unless it can be demonstrated that the requirements were fully met during FY 2000.
- Travels to support MFIS activities.

Knowledge and Skills Required by Position:

- Possesses effective written and oral communication skills.
- Possesses effective presentation skills.
- Has extensive knowledge of the Medicare program, both Part A and Part B.
- Has working knowledge and/or experience in one or more of the following fields:
  - Health care delivery system;
  - Health insurance business; and
  - Law enforcement.
- Has demonstrated organizational, analytical, and coordination skills to effectively coordinate and schedule meetings, conferences, and training.
- Has ability to work independently.

### **3.2.6 – Security Requirements{tc "3.2.6 – Security Requirements" \1 3}**

Contractors must ensure a high level of security for this sensitive function. Fraud unit staff, as well as all other contractor employees, must be adequately informed and trained so that information obtained by, and stored in, the fraud unit is kept confidential.

Physical and operational security within the fraud unit is essential. Operational security weaknesses in the fraud unit's day to day activities may be less obvious and more difficult to identify and correct than physical security. The fraud unit's interaction with other contractor operations, such as the mailroom, could pose potential security problems. Guidelines that should be followed are discussed below.

#### **A – Privacy of Fraud Unit Operations**

Fraud unit activities are to be conducted in areas not accessible to the general public. Other requirements include:

- Limiting access to fraud unit sites to only those who need to be there on official business (Tours of the contractor should not include the fraud unit.);
- Ensuring that discussions of highly privileged and confidential information cannot easily be overheard by surrounding units. Ideally, the unit is located at the end of a passageway; does not have an entrance or exit to the outside; and has a private office for the manager;
- Ensuring that visitors to the fraud unit who are there for official purposes, unrelated to fraud unit functions (e.g., cleaning crews, mail delivery personnel, technical equipment repair staff) are not left unobserved; and

- Securing the fraud unit site when it is not occupied by fraud unit personnel. Where the fraud unit shares space with other contractor components, all sensitive documents must be stored in locked file cabinets or private offices in the absence of fraud unit staff.

## **B – Handling and Physical Security of Sensitive Material**

Consider all fraud and abuse allegations and associated case development material to be sensitive material. The term "sensitive material" includes, but is not limited to, fraud unit case files and related work papers (correspondence, telephone reports, complaints and associated records, personnel files, etc.). Improper disclosure of sensitive material could compromise an investigation or prosecution of a case; it could also cause irreparable harm to innocent parties.

The following guidelines should be followed:

- Employees should only discuss specific allegations of fraud within the context of their professional duties and only with those who have a valid need to know. This may include staff from the MR or audit units, senior management, or corporate counsel;
- Ensure the mailroom, general correspondence and telephone inquiries procedures maintain confidentiality whenever correspondence, telephone calls or other communications alleging fraud are received. All internal written operating procedures should clearly state security procedures;
- Mailroom staff should be directed not to open fraud unit mail in the mailroom. Mail being sent to CO, another fraud unit, or MFIS, should be marked "personal and confidential," and should be addressed to a specific person;
- Where not prohibited by more specialized instructions, sensitive materials may be retained at employees' desks, in office work baskets, and at other points in the office during the course of the normal work day. Access to these sensitive materials is restricted, and such material should never be left unattended;
- When not being used or worked on, such materials should be retained in locked official repositories such as filing cabinets or safes. Such repositories should be locked at the end of the work day and at other times when immediate access to their contents is not necessary;
- Where such materials are not returned to their official repositories by the end of the normal work day, they must be placed in some other locked repository (e.g., an employee's desk);
- Contractors establish procedures for safeguarding keys, combinations, codes and other mechanisms, devices or methods for achieving access to the work site and to lockable official repositories. The contractors limit access to keys, combinations, etc., and maintain a sign off log to show the date and time when repositories are opened and closed, the documents accessed, and the name of the person accessing the material; and
- The unit maintains a "controlled" filing system. (see PIM Chapter 1, §3.2.4.1).

## **C – Designation of a Security Officer**

The fraud unit manager will designate an employee to serve as the security officer of the unit. The security officer's responsibilities will include:

- Continuous monitoring of component operations to determine whether the basic security standards noted below are being observed;
- Correcting violations of security standards immediately and personally, where practicable, and within his/her authority. (This refers to locking doors mistakenly left open, switching off electronic equipment left on after the employee using it has departed for the day, locking file cabinets or safes left unlocked in error, and similar incidents where prompt action is called for.); and
- Reporting violations of security standards to the appropriate supervisory authority, so that corrective and/or preventive action can be taken.

The fraud unit manager or a designee will:

- Review their general office security procedures and performance with the security officer at least once every 6 months;
- Document the results of the review for office administrative files; and
- Take such action as is necessary to correct breaches of the security standards and to prevent recurrence.

## **D – Staffing of the Fraud Unit and Security Training**

The fraud unit manager must ensure that fraud unit employees are well suited to work in this area and that they receive appropriate training.

Fraud unit employees should be mature and experienced individuals with easily verifiable character references and records of permanent employment.

The fraud unit manager should ensure the following:

- Thorough background and character reference checks should be performed for potential employees to verify their suitability for employment with the fraud unit;
- In addition to conducting a thorough background investigation, potential employees should be asked whether their employment in the fraud unit might involve a conflict of interest;
- Existing employees should be required annually to fill out a conflict of interest declaration as well as a confidentiality statement;
- The special security considerations under which the fraud unit operates should be thoroughly explained and discussed; and

- Persons working in the fraud unit should be paid comparable salaries to those in other areas of contractor operation.

## **E – Access to Information**

Contractor and HCFA managers, should have routine access to sensitive information if the contractors and HCFA managers are specifically authorized to work directly on a particular fraud case or are reviewing cases as part of a CPE review. This includes physician consultants who may be assisting the fraud unit and whose work may benefit by having specific knowledge of the particular fraud case.

Employees not directly involved with a particular fraud case should not have routine access to sensitive information. This includes the following:

- employees who are not part of the Medicare contractor;
- corporate employees working outside the Medicare division;
- clerical employees;
- new employees; and
- MFISs.

Temporary employees, such as those from temporary agencies, students, and non-citizens are not to be employed in the fraud unit.

While contractor management may have access to general case information, it should not request specific information about cases that the fraud unit is actively developing. The OIG should be notified if parties without a need to know are asking inappropriate questions. The unit refers media questions to the HCFA press office.

Employees should keep in mind that any party that is the subject of a fraud investigation is likely to use any means available to obtain information that could prejudice the investigation or the prosecution of the case. As previously noted, contractors do not release information to any person that is not personally known to the contractor, including provider representatives and lawyers.

Although these parties may assert that certain information must be provided to them based on their "right to know," contractors have no legal obligation to comply with such requests. The contractors should request the caller's name, organization, and telephone number. Indicate that verification of whether or not the requested information is authorized for release before response may be given. Before furnishing any information, however, contractors must definitely determine that a caller has a "need to know," and that furnishing the requested information will not prejudice the case or prove harmful in any other way.

## **F – Computer Security**

Access to computers should be granted only to fraud unit employees. The following guidelines should be followed:

- Access to particular computer databases should be given only to employees who need such access to perform their official duties. This means that employees may have access to some databases but not others;
- Passwords permitting access to particular databases will be kept at the level of confidentiality specified by supervisory staff. Employees entering their passwords should ensure that it is done at a time and in a manner that prevents unauthorized persons from learning them;
- Computer files with sensitive information should never be filed or backed up on the hard drive of personal computers. Unless the hard drive is a removable one that can be secured at night, the presumption is that a computer with a fixed hard drive is not secure. The only files to be stored permanently on the computer hard drive are applications software;
- Permanent storage on a floppy disk is a safe and efficient way to preserve data and enhances security, since the disks can be locked up. The concept is to write directly to a floppy disk. An option is to use the hard drive for storage until the product is completed, then transfer the file to a floppy disk for permanent storage and delete it from the hard drive;
- Another safe and efficient way to preserve data is to back it up. Backing up data is similar to copying it, except that back-up utilities compress the data so that less disk space is needed to store the files;
- Record sensitive information on specially marked floppy disks and control and file these in a secure container. Check computers used for sensitive correspondence to ensure that personnel are not filing or backing up files on the hard drive. The configuration of the software needs to be checked before and after the computer is used to record sensitive information; and
- Limit the storage of sensitive information in provider files with open access, particularly those in computer systems, until formal indictment occurs. Conclusions, summaries and other data that indicate who will be indicted should be in note form and not entered into open systems - even those with passwords. Personal computers with password security and a key lock are not secure.

Environmental security measures should also be taken as follows:

- Electronically recorded information should be stored in a manner that provides protection from excessive dust, moisture and temperature extremes;
- Computers should be protected from electrical surges and static electricity by installing power surge protectors;
- Computers should be turned off if not being used for extended periods of time;

- Computers should be protected from obvious physical hazards, such as excessive dust, moisture and extremes of temperature; and
- Class C (electrical) fire extinguishers should be readily available for use in case of computer fire.

## **G – Telephone Security**

The unit implements phone security practices and, if at all possible, avoid discussing specific information about a case under investigation over the phone. The employees avoid using names or other specific information that could allow another party to identify the case being discussed. They discuss cases only with those individuals that have a **need to know** the information and never divulge information to individuals not personally known to the contractor.

This applies to persons unknown to the contractor who say they are with the FBI, OIG, DOJ, etc. Only use HCFA, OIG, DOJ, and FBI phone numbers that can be verified. Management should provide fraud unit staff with a list of the names and telephone numbers of the individuals of the authorized agencies that the contractor deals with and ensures that this list is properly maintained and periodically updated.

Employees are polite and brief in responding to phone calls, but do not volunteer any information or confirm or deny that an investigation is in process. Personnel are especially cautious of callers who "demand" information and continue to question the contractor after it has stated that it is not at liberty to discuss the matter. Again, it is necessary to be polite, but firmly state that the information cannot be furnished at the present time and that the caller will have to be called back. Contractors do not respond to questions concerning any case being investigated by the OIG or FBI. The contractors refer them to the OIG or FBI, as appropriate.

Transmit sensitive information via facsimile (FAX) lines only after it has been verified that the receiving FAX machine is secure. Contractors make arrangements with the addressee to have someone waiting at the receiving machine while the FAX is being transmitted. Never transmit sensitive information via FAX when it is necessary to use a delay feature such as entering the information into the machine's "memory".

### **3.3 – DMERC Fraud Functions**

On October 1, 1993, separate Medicare carriers were established to pay and review claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). CFR 414.202 describes these items in fuller detail. As Medicare carriers, DMERCs are subject to all fraud unit requirements applicable to other carriers.

The fraud detection and case development function resides in the DMERC fraud unit which is Medicare dedicated and physically and organizationally identifiable as a separate unit. The unit is led by a full-time fraud unit manager (see Exhibit 17 for a list of Medicare fraud unit managers Exhibit 19 for a list of DMERC Program Integrity Coordinators). The decisions of the fraud unit manager as they pertain to the referral of fraud cases to OIG are not subject to the review by DMERC management.

DMERCs shall process all complaints alleging DMEPOS fraud that are filed in its region in accordance with requirements of PIM Chapter 2, §3ff. (See Exhibit 20 for a list of DMERC regional carrier jurisdictions.) The fraud unit manager has responsibility for all fraud unit activity including the coordination with outside organizations as specified in the PIM Chapter 1, §7.2.1.

## **A – General Requirements**

Since the Medicare program has become particularly vulnerable to fraudulent activity in the DMEPOS area, each DMERC must:

- Routinely communicate with and exchange information with its MR unit and ensure that referrals for prepayment MR review or other actions are made;
- Consult with DMEPOS Medical Directors Workgroup in cases involving medical policy or coding issues;
- Fully utilize data available from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) to identify items susceptible to fraud; and
- Keep other DMERCs, the SADMERC, and HCFA RO and CO staff informed of its ongoing activities and share information concerning aberrancies identified using data analysis, ongoing and emerging fraud schemes identified, and any other information that may be used to prevent similar activity from spreading to other jurisdictions.

## **B – Use of National Supplier Clearinghouse (NSC) Alert Codes**

DMERCs initiate appropriate and immediate action in cases where a supplier has had its file appended with a NSC alert code, indicating the company may have committed fraud or abuse. The following is a list of general definitions of current NSC alert codes:

- "A" - Possible/suspect fraud and abuse.
- "B" - Overpayment - believe uncollectible.
- "C" - Violation of supplier standards.
- "D" - Violation of disclosure of ownership.
- "E" - Violation of participation agreement.
- "F" - Sanctioned by the OIG.
- "G" - Special review of existing supplier.
- "H" - New supplier under review.
- "I" - No claims processed by specific DMERC.
- "J" - No problem claims.
- "K" - Suspend because of fraudulent claims.
- "L" - Suspended by DMERC - discovered by DMERC PI staff investigation.
- "M" - Supplier is going through the appeals process.
- "R" - Revoked supplier number.

## **C – CMN Validation**

DMERCs shall conduct one study every 6 months of DMEPOS supplier practices as they pertain to the completion of the CMN and should report the findings to HCFA. In addition,

DMERCs select a statistically valid random sample (SVRS) of DMEPOS claims processed during the previous 6-month period.

The purpose of the study is to determine whether:

- There are hard copy original CMNs supporting electronic media claims (EMC) CMN submissions;
- The supplier completed any part of the medical necessity justification before or after the physician completed and signed the justification;
- The recipients of the equipment or supplies were charged and paid deductibles and coinsurance;
- The recipients initiated the request for the item(s) or whether the recipients were approached by the supplier;
- The diagnoses and other statements in the CMNs are consistent with medical records; and
- The equipment/supplies billed were actually received by the beneficiaries and whether the items received are consistent with the items billed, e.g., if Medicare was billed for new items, verify that new, not used, items were actually furnished.

DMERCs shall determine whether CMNs meet the requirements of the PIM Chapter 5 and other applicable requirements. In making this determination, suppliers and physician offices are visited as necessary. All data available is reviewed in order to detect billing practices that are contrary to existing Medicare law, regulations and policies. DMERCs must develop fully any violations found as a result of this study and make appropriate referrals to OIG/OI.

#### **4 – Coordination of MR and Fraud Units**

The fraud unit's responsibilities include looking for potential fraud. The MR unit's responsibilities include looking for potential errors. Contractor fraud and medical review staffs must work closely together, especially in the areas of:

- data analysis; and
- identification of potential errors or potential fraud which should be referred to the other component.

The fraud and MR units must have ongoing discussions and close-working relationships regarding situations identified which may be signs of fraud. Intermediaries must also include the cost report audit unit in the ongoing discussions.

#### **A – Referrals From the MR Unit To the Fraud Unit**

If a provider appears to have knowingly and intentionally furnished services that are not covered or filed claims for services not furnished as billed, or made any false statement on the claim or supporting documentation to receive payment, the MR unit personnel shall discuss the case with the fraud unit. If the fraud unit agrees that there is potential fraud, the MR unit shall then refer the case to the fraud unit for further development. Cases involving providers who show a pattern of repeated misconduct or conduct that is clearly abusive or potentially fraudulent despite provider education and direct contact with the provider to explain identified errors must be referred to the fraud unit.

## **B – Referrals From the Fraud Unit To the MR Unit and Other Units**

The fraud unit often receives complaints alleging fraud that are determined to be errors rather than fraud. When this occurs, the fraud unit will refer the case to the MR unit.

Contractors are also responsible for preventing and minimizing the opportunity for fraud. The contractors should identify contractor procedures that may make Medicare vulnerable to potential fraud and take appropriate action. For example, contractors may determine that there are problems in the provider enrollment process that make it possible for individuals excluded from the Medicare program to obtain a provider identification number. The fraud unit needs to bring these vulnerabilities to the attention of the provider enrollment unit and monitor the situation until action is taken to correct the problem.

## **5 – MIP-PET Program{tc "5 – MIP Provider Education and Training (PET) Program"}**

The MIP-PET initiative is to promote the short and long term fiscal integrity of the Medicare Program. The MIP-PET work products concentrate on activities involving individuals or groups of identified aberrant, abusive, or fraudulent providers, physicians or suppliers who have been detected through the contractor program integrity operations (i.e. medical review, Medicare Secondary Payer (MSP), audit, and benefit integrity), and on educating the general provider, physician and supplier population on issues related to fraud and abuse.

### **5.1 – MIP-PET Activities{tc "5.1 – MIP-PET Activities" \l 2}**

Each Medicare contractor is to perform the following activities:

- Provide one on one feedback to individual providers/suppliers on specific problems identified through prepay and postpay MR. Use progressive corrective action in focusing your educational activities;
- Provide feedback to the larger provider/supplier community on widespread errors. Use data analysis and the results of MR to direct these educational activities;
- Provide general information about PI activities. This includes sharing of information on PI goals and processes with local medical societies, professional associations, and other provider/supplier organizations in order to reach as many providers/suppliers as possible;
- Issue bulletins and letters to providers/suppliers containing PI information. Unless specifically requested by the provider, eliminate special bulletins and letters to all

providers/suppliers with no billing activity in the prior 12 months. Bulletins should be posted on contractor websites where duplicate copies may be obtained by providers/suppliers. (Refer to the Program Management-Provider Education and Training (PM-PET) section for posting instructions.) All bulletins/newsletters must have a header/footer that includes the following bolded language: **“THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. Additional copies may be downloaded from our website at (insert contractor website address).”**;

- Assure prompt, accurate, and courteous replies to all incoming phone calls and letters seeking educational information, clarifications, etc.; and
- Promote interaction and coordination among the fraud unit, medical review unit, provider/supplier enrollment unit, etc. This interaction and coordination is essential in determining the appropriate training and education that is needed to provide proper feedback to both individual and groups of providers.

As time and funding permits the following activities can be funded through MIP-PET.

- Provide remedial education to Administrative Law Judges (ALJs) about MIP-related policies and administrative procedures.
- As requested participate in presentations at fraud and abuse programs arranged by health care provider/supplier groups.
- Address medical/specialty groups to answer their issues and concerns.
- Prepare/distribute computer based training modules, videos, and other materials that address Medicare PI issues.

## **6 – Contractor Medical Director (CMD){tc "6 – Contractor Medical Director (CMD)" }**

Contractors must employ a minimum of one full time equivalent (FTE) medical director and arrange for an alternate when the CMD is unavailable for extended periods. Waivers for very small contractors may be approved by the RO. The CMD FTE must be composed of no more than two physicians. All physicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties are listed below.

Primary duties include:

- Leadership in the provider community, including:
  - Interacting with medical societies and peer groups;

- Educating providers, individually or as a group, regarding identified problems or LMRP; and
- Acting as co-chair of the Carrier Advisory Committee (CAC) (see PIM Chapter 1 §2.7.4 for co-chair responsibilities).
- Providing the clinical expertise and judgment to develop LMRPs and internal MR guidelines:
  - Serving as a readily available source of medical information to provide guidance in questionable claims review situations;
  - Determining when LMRP is needed or must be revised to address program abuse;
  - Assuring that LMRP and associated internal guidelines are appropriate;
  - Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
  - Selecting consultants licensed in the pertinent fields of medicine for expert input into the development of LMRP and internal guidelines;
  - Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;
  - Providing the clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse; and
  - Serving as a readily available source of medical information to provide guidance in questionable situations.

Other duties include:

- Interacting with the CMDs at other contractors to share information on potential problem areas;
- Participating in CMD clinical workgroups, as appropriate; and
- Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.

To prevent conflict of interest issues, the CMD must provide written notification to CO ([MROperations@hcfa.gov](mailto:MROperations@hcfa.gov)) and RO, as well as to the CAC, within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, CMDs who are currently in practice should notify their RO of the type and extent of the practice.

## **7 – Other Program Integrity (PI) Requirements**

### **7.1 – Request for Information from Outside Organizations**

Contractors must comply with the requirements in Exhibit 2 regarding requests for information from outside organizations.

### **7.2 – Contractor Coordination With Other Contractors and Peer Review Organizations (PROs)**

Contractors should coordinate with other contractors (intermediaries, carriers, DMERCs, and RHHIs) within their service area. This includes sharing LMRPs, and collaboration on abusive billing situations that may be occurring in multi-state contractors. Coordination is also necessary because certain findings of fraud involving a provider could have a direct effect on payments made by other contractors. Contractors use the MFIS when there is a need to share information with Medicare contractors not in contiguous States.

Contractors should notify PROs of referrals to OIG/OI. OIG/OI may need to make a referral to the PRO in order for the PRO to request approval of contract modifications in accordance with HCFA instructions.

Carriers must meet with the PRO in its State 3-4 times a year to discuss LMRPs and to jointly develop new policies, as appropriate. Communication with the PRO is essential to discuss the potential impact of efforts to prevent abuse as well as efforts to ensure quality and access. More specifically, HCFA expects dialogue between contractors and the PRO to:

- Ensure that LMRP does not set up obstacles to appropriate care;
- Articulate the program safeguard concerns or issues related to PRO activities; and
- Be aware of PRO initiatives (e.g., PRO project to encourage Medicare beneficiaries to get eye exams), so they do not observe an increase in utilization and label it overutilization.

Contractors will continue exchanging additional information such as data analysis methods, data presentation methods, and successful ways to interact with providers to change behavior. This includes special projects that contractors and the PRO have determined to be mutually beneficial.

It is essential that the fraud unit manager maintain an ongoing dialogue with his/her counterpart(s) at other contractors, particularly in contiguous States. This ensures that a comprehensive investigation is initiated timely and prevents possible duplication of investigation efforts.

#### **7.2.1 – Contractor Coordination with Other Entities**

Contractors must establish and maintain formal and informal communication with state survey agencies, OIG, General Accounting Office (GAO), Medicaid, other contractors (intermediaries with carriers and vice versa), and other organizations as applicable to determine information that is available and which should be exchanged to enhance PI activities.

If a contractor identifies a potential quality problem with a provider or practitioner in its area, it refers such cases to the appropriate entity, be it the PRO, State medical board, State licensing agency, etc. Any provider-specific information must be handled as confidential information.

### **7.3 – Beneficiary, Provider, Outreach Activities**

Medicare fraud units produce a wide variety of outreach items and materials for beneficiary and provider education and awareness. These items include: brochures, flyers, stuffers, pens, pencils, newspaper advertisements, public service announcements, pamphlets, and videos, to list a few.

## **Medicare Program Integrity Manual**

### **Chapter 2 - Identifying Potential Errors and Potential Fraud**

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## **1 – Identifying Potential Errors - Introduction**

This chapter specifies resources and procedures contractors must use to identify and verify potential errors to produce the greatest protection to the Medicare program. Contractors should objectively evaluate potential errors and not take administrative action unless they have verified the error and determined that the error is a high enough priority to justify the action. (See Reliable Evidence in Exhibit 4.)

## **2 – Data Analysis**

Data analysis is an excellent tool for identifying potential errors. Data analysis is the comparison of claim information and other related data (e.g., the provider registry) to identify potential errors and/ or potential fraud by claim characteristics (e.g., diagnoses, procedures, providers, or beneficiaries) individually or in the aggregate. Data analysis is an integrated, on-going component of MR and BI activity.

The MR unit and the fraud unit analyze the same claims data to detect potential errors, even though the units are looking at the data from slightly different perspectives. It is wasteful to duplicate the downloading and basic arraying of data when a single request and format serve the needs of both units. Therefore, the MR and fraud units must coordinate data requests and analysis results.

The contractor's ability to make use of available data and apply innovative analytical methodologies is critical to the success of the MR and BI programs. Contractors should use research and experience in the field to develop new approaches and techniques of data analysis. Ongoing communication with other government organizations (e.g., PROs, the State Medicaid agencies, fiscal intermediaries, carriers and the DMERCS) concerning new methods and techniques should occur.

Analysis of data should:

- Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk;
- Establish baseline data to enable the contractor to recognize unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;
- Identify where there is a need for LMRP;
- Recommend claims review strategies to most efficiently prevent or address potential errors (e.g., prepayment edit specifications or parameters);
- Produce innovative views of utilization or billing patterns that illuminate potential errors;
- Recommend where there is a need to target high volume or high cost services that are being widely overutilized. This is important because these services will not appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk;

- Evaluate, on a random basis, billing patterns that lie in the norm. This approach is crucial to respond to those providers who ascertain contractor strategies for targeting corrective actions and seek to avoid scrutiny; and
- Recommend strategies for review of claims that add an element of unpredictability in terms of what providers or services will be targeted.

This data analysis program must involve an analysis of national data furnished by HCFA as well as review of internal billing utilization and payment data to identify potential errors.

The goals of the contractors' data analysis program are to identify errors that pose the greatest financial risk to the Medicare program.

Contractors must document the processes used to implement their data analysis program and provide the documentation upon request.

In order to implement a data analysis program, the contractor must:

- Collect data from sources such as:
  - Historical data, e.g., review experience, denial data, provider billing problems, provider cost report data, Provider Statistical and Reimbursement (PS&R) data, billing data, Common working File (CWF), data from other Federal sources, i.e., PRO, other carriers and fiscal intermediaries (FIs), Medicaid; and
  - Referrals from internal or external sources (e.g., provider audit, fraud and abuse unit, beneficiary, or other complaints);
- Conduct data analysis to identify potential errors;
- Verify existence of errors;
- Develop edit criteria, if needed, that inform providers on coverage and correct billing practices; and
- Institute ongoing monitoring and modification of data analysis program components.

## **2.1 – Data Analysis to Detect Potential Errors or Potential Fraud**

The data sources that contractors use will depend upon the issue(s) being addressed and the availability of existing data. Some of the more obvious provider information that may be used include:

- Types of providers;
- Volume of business;

- Volume (or percentage) of Medicare/Medicaid patients;
- Prevalent types of services;
- Location;
- Relationships to other organizations;
- Types of ownership;
- Previous investigations by the fraud unit;
- Size and composition of staff;
- Administrative costs;
- Claims history; and
- Other information needed to explain and/or clarify the issue(s) in question.

Systematic data analysis requires contractors to have in place the hardware and software capability to profile providers in aggregate, by provider type, by common specialties among providers, or individually. Specific requirements are described in PIM Chapter 2 §2.4.2 – Document Data Strategy.

Where possible, the selection of providers should show a representative grouping in order to accurately reflect the extent of program losses.

### **2.1.1 – Resources Needed for Data Analysis**

Contractors must have available sufficient hardware, software, and personnel with analytical skills to meet requirements for identifying problems efficiently and developing and implementing corrective actions. If carriers and intermediaries are unable to employ staff with the qualifications/expertise to aid in an effective analysis, they may use other entities (e.g., universities, consultants, other contractors) who can provide the technical expertise needed. The following are minimum resource requirements for conducting data analysis.

#### **A – Data Processing Hardware**

Adequate equipment for data analysis includes facilities to process data (i.e., mainframes and personal computers) and to store data (i.e., tape drive, disk drives, etc.). Upgrading current resources (i.e., mainframe computers, shared systems, etc.) or the purchase of new capabilities (i.e., microcomputer workstations or subcontracts for computer services) may provide additional processing capabilities. In addition, contractors must have telecommunication capabilities to interact with the HCFA Data Center.

#### **B – Data Processing Software**

HCFA provides contractors with software to allow communication with the HCFA Data Center. Contractors may wish to develop or acquire additional software that allows for analysis of internal data or other data obtained from the HCFA Data Center. Contractors should have internal software to support the analyses of data to meet program goals.

## **C – Personnel**

Contractors must have staff with appropriate training, expertise and skills to support the application of software and conduct systematic analyses and clinical evaluation of claims data. HCFA strongly encourages contractors to have staff with clinical expertise (e.g., registered nurses) and a mix of skills in programming, statistics, and data analysis (e.g., trending and profiling of providers/codes).

Contractors must also employ staff that have training to develop analytical and sampling strategies for overpayment projections.

### **2.1.2 – The “ARGUS” System**

ARGUS is a user friendly personal computer software package developed by the OIG both to access provider claims data and to limit the need for the OIG to submit multiple requests to carriers for claims data. ARGUS is a useful tool for reviewing relationships of data that carriers have available. The billing practices of physicians, for example, can be compared to that of their peers as a means of detecting aberrant behavior.

OIG has trained a representative from each contractor fraud unit to use ARGUS.

OIG and other authorized Federal law enforcement agencies request claims data as they have in the past, but do not specify how the data is to be sorted. They specify the providers and the dates of service. ARGUS, which is written in DBASE, utilizes line item claims data provided by Medicare carriers in a simple ASCII format and separates the incoming data into database fields.

An investigative file in ARGUS is a database file consisting of individual line items of service taken from health insurance claims forms. Each line item consists of 29 fields and 160 bytes of information. Line items from a single provider or from multiple providers involved in a specific investigation may be combined into one ARGUS file.

When contractors receive a request for data, they complete the data elements contained in PIM Chapter 9 §4 (ARGUS Field Descriptions and Codes), in the order shown, and consistent with the following data conventions:

- All character fields are left justified.
- Leading zeros and blanks are omitted.
- All numeric fields are right justified.
- Money fields are shown as \$\$\$cc (no decimal point).

- All dates are shown as YYMMDD.

Data are to be furnished in the above format on 3 1/2 inch, high density, floppy disks. If the data does not fit on the 3 1/2-inch disk without data compression, carriers compress the data using the PKZIP compression utility. Data will be transmitted electronically to OIG.

## **2.2 – Frequency of Analysis{tc "2.2 – Frequency of Analysis" \l 2}**

Contractors must have at least 18 months of data to track patterns and trends. The contractors must, at a minimum, compare the current 6-month period to the previous 6-month period to detect changes in providers' current billing patterns and to identify trends in new services. Summary data or valid samples can be used when dealing with very large volumes of data.

## **2.3 – Sources of Data{tc "2.3 – Sources of Data" \l 2}**

### **A – Primary Source of Data**

Claims data is the primary source of information to target abuse activities. Sources of claims data are:

- National Claims Data – Contractors should utilize the reports accessible from HCFA's Customer Information System (HCIS). Carriers utilize the HCFA Data Center's Part B Extract Summary System (BESS), especially the Focused Medical Review (FMR) reports which show comparative utilization ratios by code, carrier, and specialty. Intermediaries must use national data where available. National data for services billed by SNFs and home health agencies (HHAs) is available at the HCFA Data Center; and
- Contractor Local Claims Data – Local data should be compiled in a way to identify which providers in the contractor's area may be driving any unusual utilization patterns.

### **B – Secondary Sources of Data**

Contractors should consider other sources of data in determining areas for further analysis. These include:

- OIG and GAO reports;
- Fraud alerts;
- Beneficiary and provider complaints;
- Referrals from the PRO, other contractors, HCFA components, Medicaid fraud control units, Office of the U.S. Attorney; or other federal programs;
- Suggestions provided directly or implicit in various reports and other materials produced in the course of evaluation and audit activities, e.g., contractor evaluations, State assessment, HCFA-directed surveys, contractor or State audits of providers;

- Referrals from medical licensing boards;
- Referrals from the CAC;
- Information on new technologies and new or clarified benefits;
- Provider cost reports (Intermediaries);
- Provider Statistical and Reimbursement (PS&R) System data (Intermediaries);
- Enrollment data;
- Common Working File (CWF);
- Referrals from other internal and/or external sources (e.g., statistical analysis DMERC, MR, intermediary audit staff or, carrier quality assurance (QA) staff); and
- Any other referrals.

While the contractor should investigate reports from the General Accounting Office (GAO), congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG OI, the MFIS, newspaper and magazine articles, as well as local and national television and radio programs, highlighting areas of possible abuse, these types of leads should not be used as a main source for leads on fraud cases.

## **2.4 – Steps in the Analysis Process**

### **2.4.1 – Determine Indicators to Identify Norms and Deviations**

Contractors should develop indicators used to identify norms, abnormalities, and individual variables that describe statistically significant time-series trends and the most significant abnormalities or trends. Examples of indicators or variables are:

- Standard deviations from the mean;
- Percent above the mean or median;
- Percent increase in charges, number of visits/services from one period to another.

### **2.4.2 – Document Data Strategy**

While HCFA is deliberately not prescriptive in terms of the technical details of how contractors reach data analysis goals, contractors are expected to develop the most sophisticated and effective methods and procedures to meet these goals and will be held accountable for effective reports, procedures, and outcomes.

At a minimum, the contractor's strategy should include a listing of the report or data view capabilities of the system, the frequency at which these reports are generated, and the process for establishing which statistical outlier or other patterns should be pursued as abuse. Examples of the system report or data view capabilities are:

- Total allowed charges;
- The total number of allowed services provided;
- Total number of services per beneficiary receiving services;
- The number and/or percent of denials; and
- Diagnosis codes billed with HCFA Common Procedure Coding System (HCPCS) codes.

### **2.4.3 – Determine Data to Review**

#### **2.4.3.1 – Intermediary Review**

Intermediaries develop reports that profile providers by comparing national, when data is available, and local utilization by type of service and diagnosis. At a minimum, intermediaries analyze paid claim history data every 6 months. In addition, intermediaries use any of the data sources listed in PIM Chapter 2, §2.3.

The following are examples of where intermediaries may begin analysis:

- Services most likely to be over-utilized or used inappropriately;
- New technologies or new or clarified benefits;
- Comparison of similar providers in terms of case mix, bed size, geographical area, number of services and charges;
- Information regarding findings on over-utilized services or specific providers;
- Revenue codes or HCPCS codes that reflect the most variation among providers in frequency per beneficiary;
- Most frequently occurring diagnoses; and
- Services that have shown significant changes in practice patterns from year-to-year.

Below is a list of examples of potential areas for prepayment and post-payment review for intermediaries. Although the list is by bill type, some examples may apply to more than one bill type. This list should not be considered comprehensive. Contractors must develop other ways to use data to identify areas on which to focus.

## **A – Outpatient Claims**

- Establish norms for type and frequency of services by beneficiary for specific diagnoses;
- Compare providers to the norm to identify outliers;
- Compare Rural Health Clinics (RHC) and outpatient hospital utilization for the same services to identify any significant differences in utilization patterns that may need to be addressed;
- Compare physicians' services on RHC claims to those allowed for similar services by the area carrier. If RHC visits are significantly higher, consider using the carrier's medical policy;
- Compare frequency of services (e.g., laboratory tests, diagnostic procedures) by beneficiary for providers with similar demographics;
- Profile physicians by Unique Physician Identification Number (UPIN) to determine if a provider aberrancy may be physician specific;
- Profile physicians for therapy services to determine if the same physician signs all or most care plans in areas where you would expect the patient's private physician to sign;
- Compare local carrier utilization for supplier services with your provider utilization for the same services;
- Perform trend analysis over a period of time for therapy providers. If services have dramatically increased, determine whether the number of patients increased or the number of visits per patient increased. Determine whether the provider increased staff commensurate with the increase in visits; and
- Profile therapy visits to identify providers billing consistently just below the HCFA therapy parameters or other parameters which you are using.

## **B – End State Renal Dialysis (ESRD) Claims**

- Compare occurrences of services billed outside the composite rate; and
- Profile frequency of specific tests, pharmacy, and additional dialysis sessions by beneficiary. Establish norms, and identify outliers.

## **C – SNF Claims**

- Compare incidence of patients receiving specific ancillary services to total patients among SNFs. Focus on SNFs with highest levels; and

- Compare lengths of stay or average covered days billed among SNFs. Focus on SNFs that are significantly aberrant.

## **D – HHA Claims**

- Profile UPINs of physicians signing plans of care to identify arrangements with specific physicians and the possibility of physicians with financial relationships with HHAs;
- Develop patterns from your data for HHAs with similar demographics, e.g., frequency of visits, visits per beneficiary, and lengths of stay, and compare to utilization of specific HHAs. Compare proprietary utilization to nonprofit or visiting nursing associations;
- Compare State utilization to regional norms;
- Sample beneficiaries within HHAs to identify questionable patterns such as frequent new start of care dates or unusual changes in primary diagnoses;
- Look for the same beneficiaries served by more than one HHA;
- Compare utilization of daily visits by HHAs among HHAs of similar size and nearby service area;
- Compare incidence of patients receiving therapy or medical social work services;
- Compare incidence of diagnoses to identify any unusual pattern of diagnoses, e.g., cataract, pernicious anemia; and
- Conduct an analysis over a period of time. If services have dramatically increased, determine whether the number of patients or the number of visits per patient increased. Determine whether the HHA increased staff commensurate with the increase in visits. Look for unusually large rates of increase.

## **E – Hospice Claims**

- Look at patterns of unusually long lengths of stay;
- Look at patterns of vague or questionable diagnoses, i.e., diagnoses which are not normally considered to be terminal within six months; and
- Look at unusual patterns of services occurring for hospice beneficiaries, which are unrelated to their terminal illnesses.

## **3 – Complaints{tc "3 – Complaints"}**

Complaints may be presented by telephone, in writing, or in person. Beneficiaries, as recipients of Medicare covered services, are in a unique position to assist in detecting program fraud or abuse. Likewise, employees of providers are often good sources. Regardless of the complainant,

it is essential that the contractor be perceived as being genuinely interested in learning of abusive and fraudulent practices and as acting promptly on such referrals. Telephone representatives should be instructed not to advise beneficiaries to "work it out" with, or to re-contact, the provider. Also, telephone representatives should not require that the complaint be put in writing. Contractors must review complaints against specific criteria developed and documented jointly by the fraud and MR units to determine whether a complaint alleges abuse and should be referred to the MR unit or it alleges fraud and should be referred to the fraud unit. If complaints reviewed by the fraud unit turn out to be abuse, they are to complete development of the case and refer it to the MR unit for further action. The fraud unit frequently refers complaints to the MR or correspondence unit since the complaint may not be one of fraud. The fraud unit retains a copy of the development for the files and follows-up with the MR unit to ascertain and document any actual dollars saved as a result of referrals.

If all incoming complaints are processed by the fraud unit, it re-routes complaints, retaining only those that appear to allege fraud. In determining costs attributable to the fraud unit, the fraud unit calculates using the percentage of complaints retained for development.

If a contractor component other than the fraud unit reviews complaints upon receipt in the mailroom:

- The screening component uses criteria defining a complaint of fraud developed by the fraud unit; and
- The fraud unit pays a share of the screening costs based on the percentage of complaints referred.

To the greatest extent possible, the fraud unit should be able to confirm that complaints of fraud are being properly routed to the fraud unit.

### **3.1 – Definition of a Complaint**

A complaint is a statement, oral or written, alleging that a provider, supplier, or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services. Use this definition for workload reporting purposes on Schedule G. Examples of complaints include:

- Allegations that items or services were not received;
- Allegations that items or services were not furnished as shown on the Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU) or Medicare Summary Notice (MSN), or that the services were not performed by the provider shown;
- Allegations that a provider is billing Medicare for a different item or service than that furnished;
- Allegations that a provider or supplier has billed both the beneficiary and Medicare for the same item or service;

- Allegations regarding waiver of copayments or deductibles;
- Allegations that a supplier or provider has misrepresented itself as having an affiliation with an agency or department of the State, local, or Federal government, whether expressed or implied; and
- Beneficiary inquiries concerning payment for an item or service, that in his/her opinion, far exceeds reasonable payment for the item or service that the beneficiary received (e.g. the supplier or physician has "up-coded" to receive higher payment).

The following are not examples of a fraud complaint:

- Complaints or inquiries regarding Medicare coverage policy;
- Complaints alleging assignment violations;
- Excessive charges;
- Complaints regarding the appeals process;
- Complaints over the status of a claim;
- Requests for an appeal or reconsideration; or
- Complaints concerning providers or suppliers (other than those complaints meeting the criteria established above) that are general in nature and are policy or program oriented.

Complaints alleging malpractice or poor quality of care may or may not involve a fraudulent situation. These must be reviewed and determined on a case by case basis. Refer complaints alleging poor quality care to the Medicare/Medicaid survey and certification agencies and the PRO.

### **3.2 – Acknowledgment of Complaints**

Contractors acknowledge complaints, in writing, on average, within 45 calendar days after receipt in the mailroom unless the complaint can be disposed of within 45 days. Forwarding the complainant a copy of the inquiry sent to the provider is not an acknowledgment. In the acknowledgment, contractors thank the complainant for his/her interest and for bringing the matter to light. The contractors explain that there will be an investigation and notify the complainant as soon as the investigation is completed. Contractors indicate when the investigation is to be completed. Acknowledge complaints referred to other components, such as medical review, for their action, explaining the reason for the referral, e.g., why the matter is not a fraud matter.

Refer any complaints that are not handled to the appropriate contractor. For example, a complaint regarding a DME supplier should be referred to the appropriate DMERC in the region. (See PIM Exhibit 19.) Instruct contractor staff that if they should receive a complaint of this

nature, they are to take the complaint and inform the complainant that it will be referred to the appropriate contractor.

For OIG hotline referrals, contractors send an acknowledgment to the RO within 30 calendar days of receiving the referral. If the complaint is not resolved within 30 calendar days of the date of the acknowledgment, the contractors send a report to the RO. The report includes a brief summary of all actions taken and contacts with OIG/OI. Contractors control all OIG Hotline referrals by the OIG Hotline number (the "H or L" number) as well as by any numbers used in the tracking system. Contractors refer to this number in all correspondence to the RO.

### **3.3 – Maintenance of Complaint Case Files**

Contractors control incoming complaints, and check each against fraud unit files for other complaints involving the same provider. Complaint files, organized by provider or supplier, should contain all pertinent documents, e.g., original referral or complaint, investigation findings, reports of telephone contacts, warning letters, documented discussions and decision memoranda regarding final disposition of the case. They retain records for 7 years. Contractors close out complaints that are definite misunderstandings. (See PIM Chapter 2, §3.5.)

Contractors resolve any potential fraud or abuse situations without referral to OIG/OI, if possible, and maintain all documentation on these cases for subsequent review by OIG/OI or RO personnel.

#### **A – Source of Complaint**

Record the name of the individual (or organization) that provided the information concerning the alleged fraud or abuse. Also, list the provider's name, address, and ID number.

#### **B – Nature of Complaint**

Briefly describe the nature of the alleged fraud or abuse (e.g., "Provider billed for services not furnished;" "Beneficiary alleged provider billed for more than deductible and coinsurance.").

Also include the following information:

- The date the complaint was received;
- A brief description of the action taken to close out the complaint. EXAMPLE: "Reviewed records and substantiated amounts billed beneficiary." Insure that sufficient information is provided, enabling OIFO or the RO to understand the reason for the closeout;
- Give the date the complaint was closed; and
- List the number of complaints received to date concerning this provider, including the present complaint. This information is useful in identifying providers that are involved in an undue number of complaints.

## **3.4 – Development of Complaints**

When contractors receive an allegation of fraud, or identify a potentially fraudulent situation, they initiate action to determine the facts and the magnitude of the alleged fraud. They conduct a variety of reviews to determine the appropriateness of payments even when there is no evidence of fraud. Prioritization of the case workload is critical to ensure that the resources available are devoted primarily to high priority cases. (See PIM Chapter 1, §3.2.1.) (Consider complaints by current or former employees for early contact with OIG/OI. OIG/OI may request that contractors perform only limited internal development and then immediately refer the case to them.)

Development is establishing the factual basis for (i.e., substantiating) an allegation. A case is a written enumeration of the facts supporting the position that false claims were filed and they do not appear to be the result of an honest billing error or misinterpretation of Medicare requirements.

### **3.4.1 – Review of Complaints**

The difference between abuse and fraud reviews is essentially that the abuse situation involves a review of the propriety or medical necessity of services that are billed. Fraud reviews are geared towards determining, for example, whether or not billed services were, in fact, furnished. The MR unit reviews cases that clearly appear to be program abuse relegating potential fraud cases to the fraud unit.

When the complaint cannot be dismissed as a billing error or misunderstanding, contractors use one or more of the following methods to determine whether or not there is a pattern of submitting false claims. (The list is not intended to be all-inclusive.)

- Review a small sample of claims submitted within recent months. Depending on the nature of the problem, the contractor may need to request medical documentation or other evidence that would validate or cast doubt on the validity of the claims;
- Interview by telephone a small number of beneficiaries. Do not alarm the beneficiaries or imply that the provider did anything wrong. The purpose is to determine whether there appears to be other false claims or if this was a one-time occurrence; or
- Look for past contacts by the MR or fraud unit concerning comparable violations. Also, check provider correspondence files for educational/warning letters or for contact reports that relate to similar complaints. Review the complaint file. Discuss suspicions with MR and audit staff, as appropriate.
- The purpose is to decide whether it is reasonable to spend additional investigative resources. If there appears to be a pattern, notify OIG/OI. Discuss with OIG/OI the facts of the case and whether or not the case should be further developed for referral to OIG/OI. If not, determine whether there have been overpayments and initiate recovery action.
- If there is evidence of fraud, do not contact the provider or their office personnel. If there is belief that provider contact is necessary, consult with OIG/OI. OIG/OI

considers the situation and, if warranted, concurs with such contact. Additionally, if the suspect provider hears that its billings are being reviewed or learns of the complaint and contacts the contractor, report such contact immediately to OIG/OI.

**NOTE:** If OIG/OI declines the referral, take all appropriate action in order to prevent any further payment of inappropriate claims and to recover any overpayments that may have been made.

Additional investigative methods that may be used to develop a case include some or all of the following review activities:

- Telephone calls or written questionnaires to physicians confirming the need for home health services or DME;
- Random validation checks of physician licensure;
- Reviews of original certificates of medical necessity;
- Analysis of high frequency/high cost, high frequency/low cost, low frequency/low cost, and low frequency/high cost procedures and items;
- Analysis of local patterns/trends of practice/billing against national and regional trends beginning with the top 30 national procedures for focused medical review and other kinds of analysis that help to identify cases of fraudulent billings;
- Initiating other analysis enhancements to authenticate proper payments; and
- Compilation of documentation, e.g., medical records or cost reports.

#### **3.4.1.1 – Internal Review{tc "3.4.1.1 – Internal Review" \1 4}**

Using internal data, contractors determine the following:

- Type of provider involved in the allegation and the perpetrator if an employee of the provider;
- Type of services involved in the allegation;
- Place of services;
- Claims activity (including assigned and nonassigned payment data in the area of the fraud complaint);
- The existence of statistical reports generated for the Provider Audit List (PAL) or other MR reports to establish if this provider's practice is exceeding the norms established by their peer group. (Review the provider practice profile.); and

- Whether there is any documentation available on prior complaints. Obtain the appropriate HCFA-1490s and/or 1500s, UB-92s, electronic claims and/or attachments. Review all material available.

**NOTE:** Due to evidentiary requirements, do not write on these forms/documents in any manner.

After reviewing the provider's background, specialty and profile, contractors decide whether the situation, although it involves potentially fraudulent activity, may be more accurately categorized as a billing error. For example, records indicate that a physician has billed, in some instances, both Medicare and the beneficiary for the same service. Upon review, a carrier determines that, rather than attempting to be paid twice for the same service, the physician made an error in his/her billing methodology. Therefore, this would be considered a case of improper billing, rather than fraud involving intentional duplicate billing.

### **3.4.2 – Beneficiary Contacts**

The review, depending on the type of allegations, may consist of contacting a sample of beneficiaries that received from the provider, the same type of services that are involved in the initial complaint. Substantiated instances of possible fraud from more than a single complainant corroborate the initial complaint and strengthen the case by showing a pattern of fraud. A pattern of fraud strengthens the position that the provider had the intent to defraud.

If possible, contractors select the initial sample from the quarter in which the irregularity occurred. If this is not possible, they select from the year in which it occurred. Selecting a sample from a preceding year might identify claims for services that are too outdated to verify.

Factors to consider in selecting beneficiary claims for verification include:

- Beneficiaries having the largest proportion of services in the area under review;
- The dollars paid;
- The number of services furnished by the provider;
- The nature of the services furnished; and
- The evaluation of the beneficiary's suitability as a reference based upon medical history or other factors available. One claim for each beneficiary, together with the provider printout, is usually sufficient. ( EOMBs, NOUs or MSNs are not necessary until a case is referred for prosecution.)

Contractors use discretion in deciding whether written, telephone or personal beneficiary contact is warranted. A letter may also be useful and productive in some instances. However, telephone contact is the preferred method of beneficiary contact. Contractors should take efforts not to upset beneficiaries contacted, and use simple language in conversations or in letters.

If there are intentions to contact beneficiaries in writing, the initial letters to beneficiaries should not indicate they are from the fraud unit. Instead, contractors use generic stationary, which indicates that the request is from the contractor. This will alleviate any undue misunderstanding

by beneficiaries as to the purpose of the inquiry. Once there is a determination that an aberrancy or pattern exists, contractors substantiate this information by sending out requests to beneficiaries from the fraud unit.

There may be situations where, based on earnings criteria and/or prior experience with the provider, it may be more feasible to contact the provider first for an explanation of the complaint before proceeding with any beneficiary contacts. Additionally, there may be situations where the provider has significant earnings that might indicate the need to increase the number of beneficiary contacts. Contractors should use judgment in determining the number of beneficiaries to contact .

### **3.4.3 – Allegations Involving Noninstitutional Providers**

Contractors take the following actions.

Contact beneficiaries to ascertain whether there are further irregularities concerning the suspect's claims. If available, use assigned claims in the survey. Otherwise, use unassigned claims. Consider reviewing medical records, if appropriate.

If the first beneficiaries contacted validate the claims submitted, and no additional evidence of fraud is found, do not make any further beneficiary contacts. Instead, make direct contact with the provider for an explanation of the original complaint. If the provider satisfactorily explains the irregularity and it appears that a repetition is unlikely, close the case and recover any overpayment. Place a summary of the contact in the complaint file.

If the required beneficiary contacts result in detecting additional violations, or the provider contacts do not eliminate suspicion of fraud, consult with OIG/OI as to the nature and extent of expanded development to be undertaken in order for the case to be accepted by OIG/OI. See PIM Chapter 3, §10.1ff – Referral of Cases to OIG/OI for further information.

In any case, take the appropriate action to collect any overpayments determined. (See PIM Chapter 3, §8ff, Overpayment Procedures.)

Drawing distinctions between "nonspecialist" and "specialist" in setting dollar (earnings) thresholds for expanded review may encourage the use of mechanical characterizations of the suspect's practice or business. The criteria for expanded review distinguish between high-volume/low-cost practice or trade, and low-volume/high-cost practice or trade in setting dollar amounts. OIG/OI is responsible for establishing appropriate criteria in this area. Contact OIG/OI to determine whether the earnings criteria established for processing are acceptable.

Where the criteria are not met, contact OIG/OI by phone or mail for specific authorization to contact the provider or undertake other appropriate development.

Where the earnings criteria are met, and the initial (and expanded) review results in less than a 40 percent success ratio, contact OIG/OI for specific authorization to contact the provider.

### **3.4.4 – Allegations Involving Institutional Setting**

Contractors take the following actions.

Apply the following to reviews involving physicians' services furnished in an institutional setting. If the original complaint has been substantiated, examine medical charts for additional beneficiaries as directed by OIG/OI. Where no additional problems are discovered, no further review is necessary. Contact the physician for an explanation of the original complaint. If the irregularity is satisfactorily explained, and it appears that a repetition is unlikely, close the case and recover any overpayment. Place a summary of the complaint and a copy of the provider contact letter in the complaint file.

However, if more discrepancies are noted in the additional medical records reviewed, take the following actions:

- Question (by telephone or mail) the beneficiaries involved concerning the discrepant medical records findings. Consult with the OIG/OI when there is belief that the institutional beneficiaries are not productive witnesses; and
- If at least 40 percent of these beneficiaries substantiate the discrepancies in addition to the original complainant, refer the matter to OIG/OI for full-scale investigation. If fewer than 40 percent of these beneficiaries substantiate discrepancies in addition to the original complainant, expand the review to more beneficiary records as directed by OIG/OI.

Beneficiary contacts used as a basis for referral to OIG/OI for full-scale fraud investigation must be only those that resulted in definitive statements that the services were not furnished as billed. A definitive statement is one in which the beneficiary is certain that the services were not rendered as billed. This may be further strengthened by beneficiary personal records (e.g., a diary) that verify his/her contention. Also consider statements by relatives or friends of the beneficiary who can substantiate the allegation.

If the reviewer decides the merits of the case call for referral to OIG/OI for full-scale investigation with less than 40 percent denial rate, OIG/OI has final approval as to whether the case is to be considered for further investigation.

Regardless of whether the case is referred to OIG/OI, take the appropriate action to collect any overpayments determined. (See PIM Chapter 3 §8ff Overpayment Procedures.)

### **3.4.5 – Onsite Reviews**

There may be situations that warrant onsite reviews consisting of staff from the fraud, MR, and audit units. Joint reviews could also include staff from OIG, Office of Clinical Standards and Quality (OCSQ), and Medicaid, depending on the provider and the circumstances surrounding the review.

## **3.5 – Disposition of Complaints by Contractors**

Contractors should summarize the case and send it, with the case file, to OIG/OI. Ensure that case material is filed in an organized manner (i.e., chronological order, all pages attached with prongs or other binding material, and in the same order as summarized). Include copies of the claims (with attachments) at issue as well as copies of documentation of all educational/warning contacts with the provider which relate to this issue. Refer to PIM Chapter 3, §10.1ff – Referral of Cases to OIG/OI for further instruction on referrals to OIG/OI.

If the case has been referred to OIG/OI, inform the complainant that the case has been referred to OIG/OI, and that further requests concerning the matter should be referred to OIG/OI. Bear in mind that some cases may be sensitive and the complainant is not to be informed of the referral to OIG/OI. The fraud unit must contact OIG/OI before responding to the complainant if the case is a sensitive one. Otherwise, provide the complainant with the address of OIG/OI and the name of a contact person.

Contractors also should notify the complainant as soon as OIG/OI completes the case. Disposition is the final action on the case and includes referral to OIG/OI. OIG/OI will make a determination as to whether or not the case is to be referred to the FBI or other law enforcement agency for disposition. If adverse action is subsequently taken against the provider, explain to the complainant the action taken. Thank the complainant for his/her interest and diligence.

Close out definite misunderstandings (e.g., beneficiary alleged no service furnished by the radiologist, when in fact the radiologist read X-rays with no beneficiary contact; or the beneficiary misunderstood billing codes). Contact the provider only if the issue is an **obvious** billing error (e.g., wrong date of service, wrong patient, wrong service, health insurance (HI) number in error). Complaints alleging fraud that, after review, are found to be claims processing errors need not be referred to the fraud unit and may be closed by telephone. In all instances where a complaint was caused by claim processing or clerical error, close out the complaint and notify the complainant. Explain why no further action is warranted. This contact may be in writing or by phone. Use these notices to educate complainants of the requirements. Use this information in developing beneficiary education programs. Also, prepare a brief rationale for each closure and insert it in the case file in the event that the same problem recurs. Recurrence creates a need to re-evaluate the possibility of fraud and to determine the extent of the problem.

For OIG Hotline referrals, notify the RO as soon as the fraud unit or OIG/OI disposes of the cases. Prepare a summary of all actions taken and send it, including copies of any letters sent to OIG/OI, the final letter to the beneficiary, and/or the complainant, to the RO. Maintain the information below on these cases for subsequent review by OIG/OI or RO personnel.

Contractors refer particularly noteworthy and significant cases and/or activities to CO for consideration for an award. They send the nomination, along with supporting documentation to:

Health Care Financing Administration  
Program Oversight Branch  
Mail Stop C3-02-16  
7500 Security Boulevard  
Baltimore, MD 21244

### **3.6 –IRP**

Section 203(b)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), instructs the Secretary to establish a program to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of a sanction under §§1128, 1128A, or 1128B of the Act, or who have otherwise engaged in sanctionable fraud and abuse against the Medicare program under title XVIII of the Act.

The Medicare PI IRP was established to pay an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. This rule adds a new Subpart E to 42 CFR Part 420 (“Program Integrity: Medicare”), which consists of §§420.400 - 420.405. This new Subpart E includes provisions to implement §§203(b) of Public Law 104-191 and is entitled “Rewards for Information Relating to Medicare Fraud and Abuse.” The final rule was effective on July 8, 1998. These instructions must be implemented no later than March 1, 1999. The following information is intended as guidance to implement the final rule.

### **3.6.1 – IRP General Information**

The Medicare program will make a monetary reward only for information that leads to a minimum recovery of \$100 of Medicare funds from individuals and entities determined by the HCFA to have committed sanctionable offenses. Referrals from intermediaries and carriers to the OIG, made pursuant to the criteria set forth in the PIM Chapter 3 §11ff are considered sanctionable for the purpose of the incentive reward program.

### **3.6.2 – Information Eligible for Reward**

The information must relate to a specific situation, individual, or entity, and must specify the time period of the alleged activities. It must be relevant material information which directly leads to the imposition of a sanction, and non-frivolous. HCFA does not give a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a review or investigation by HCFA, its contractors, the OIG, the DOJ, the FBI, or any other Federal, State or local law enforcement agency.

### **3.6.3 – Persons Eligible to Receive a Reward**

The complainant should be determined to be eligible for a reward only if the initial complaint was received on or after July 8, 1998 and provides information which leads to a sanctionable offense as described in PIM Chapter 3, §11ff and Chapter 2, §3ff. In general, a reward is payable to all eligible individuals whose complaints were integral to the opening of a fraud unit case. Where multiple complaints have been received, the following guidelines should be used:

- Only complaints directly relevant to the issue/allegation investigated are eligible;
- In situations where two or more complaints of the same nature concerning the same provider/entity are received, all complaints may be eligible to share an equal portion of the reward not to exceed the maximum amount of the reward; and

- The reward should be paid to the complainant who provided sufficient, specific information to open the case as discussed above.

The contractor should make a determination of eligibility for a reward as appropriate.

### **3.6.4 – Excluded Individuals** {tc "3.6.4 – Excluded Individuals " \l 3}

The following individuals are not eligible to receive a reward under the IRP:

**A** – An individual who was, or is an immediate family member of an officer or employee of the Department of Health and Human Services (HHS), its contractors or subcontractors, the Social Security Administration (SSA), the OIG, a State Medicaid Agency, the DOJ, the FBI, or any other Federal, State, or local law enforcement agency at the time he or she came into possession , or divulged information leading to a recovery of Medicare funds. Immediate family is as defined in 42 CFR § 411.12(b), which includes any of the following:

- Husband or wife;
- Natural or adoptive parent, child, or sibling;
- Stepparent, stepchild, stepbrother, or stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; and/or
- Grandparent or grandchild.

**B** – Any other Federal or State employee, contractor or subcontractor, or an HHS grantee, if the information submitted came to his/her knowledge during the course of his/her official duties.

**C** – An individual who received a reward under another government program for the same information furnished.

**D** – An individual who illegally obtained the information he/she submitted.

**E** – An individual who participated in the sanctionable offense with respect to which payment would be made.

### **3.6.5 – Amount and Payment of Reward**{tc "3.6.5 – Amount and Payment of Reward" \l 3}

The amount of the reward will not exceed 10 percent of the overpayments recovered in the case, or \$1,000 whichever is less. Collected fines and penalties are not included as part of the recovered money for purposes of calculating the reward amount. If multiple complainants are involved in the same case, the reward will be shared equally among each complainant but not to exceed the maximum amount of the reward.

### **3.6.6 – Contractor Responsibilities**{tc "3.6.6 – Contractor Responsibilities" \l 3}

### **3.6.6.1 – Guidelines for Processing Incoming Complaints**{tc "3.6.6.1 – Guidelines for Processing Incoming Complaints" \l 4}

On or after **July 8, 1998**, any complaints received that pertain to a potentially sanctionable offense as defined by §§1128, 1128A, or 1128B of the Act, or who have otherwise engaged in sanctionable fraud and abuse against the Medicare program under title XVIII of the Act are eligible for consideration for reward under the IRP. While the complainant may not specifically request to be included in the IRP, the contractor should consider the complainant for the reward program. Complaints may originate from a variety of sources such as the OIG Hotline, contractor fraud unit, customer service representatives, etc. Contractors must inform their staff of this new program so they will respond to or refer questions correctly. Exhibit 5 provides IRP background information to assist contractor staff who field inquiries. Contractors must treat all complaints as a legitimate complaint until proven otherwise. They must refer incoming complaints to the fraud unit for case development that will follow-up according to existing internal procedures. Complaints will either be resolved by the fraud unit or if determined to be a sanctionable offense they are referred to the OIG for investigation. Complaints that belong in another contractor's jurisdiction are recorded and forwarded to the appropriate contractor. All information is forwarded to them according to existing procedures.

If an individual registers a complaint about a Medicare Managed Care provider, contractors should record and forward all information to:

The Health Care Financing Administration  
Center for Health Plans and Providers  
Performance Review Division  
Mailstop C4-23-07  
7500 Security Blvd.  
Baltimore, MD 21244-1850

### **3.6.6.2 – Guidelines for Complaint Tracking**{tc "3.6.6.2 – Guidelines for Complaint Tracking" \l 4}

Contractors must continue to track all incoming complaints potentially eligible for reward in their existing internal tracking system. The following complainant information must be included:

- Name;
- Health insurance claim number or social security number (for non-beneficiary complaints);
- Address;
- Telephone number; or
- Any other requested identifying information needed to contact the individual.

### **3.6.6.3 – Referral to OIG**{tc "3.6.6.3 – Referral to OIG" \l 4}

Contractors must refer complaints to the OIG for investigation if referral criteria is met according to PIM Chapter 3, §10.1 Referral of Cases to the Office of Inspector General(OIG). The case report should also be forwarded to the OIG.

The fraud unit enters all available information into the IRP tracking database. Information that must be maintained on the IRP tracking database include:

- Date the complaint is referred to the OIG;
- OIG determination of acceptance;
- If accepted by OIG, the date and final disposition of the complaint by the OIG (e.g., civil monetary penalty (CMP), exclusion, referral to DOJ); and
- Any provider identifying information required in the FID, e.g., the UPIN.

The OIG has 90 calendar days from the referral date to make a determination for disposition of the case. If no action is taken by the OIG within the 90 calendar days, the contractor fraud unit should begin the process for recovering the overpayment and issuance of the reward, if appropriate.

#### **3.6.6.4 – Overpayment Recovery{tc "3.6.6.4 – Overpayment Recovery" \l 4}**

Contractors must initiate overpayment recovery actions according to the PIM Chapter 3 §8ff, if it is determined an overpayment exist.

#### **3.6.6.5 – Eligibility Notification{tc "3.6.6.5 – Eligibility Notification" \l 4}**

After all fraudulently obtained Medicare funds have been recovered and all fines and penalties collected, if appropriate, the contractor will send a reward eligibility notification letter and a reward claim form to the complainant by mail at the most recent address supplied by the individual. Exhibit 5.1 provides a sample eligibility notification letter and Exhibit 5.2 provides a sample reward claim form that may be used as guides.

#### **3.6.6.6 – Incentive Reward Payment{tc "3.6.6.6 – Incentive Reward Payment" \l 4}**

After the complainant has returned the reward claim form with appropriate attachments, the fraud unit determines the amount of the reward and initiates payment. The reward payment should be disbursed to the complainant from the overpayment money recovered. Payments made under this system are considered income and subject to reporting under IRS tax law. No systems changes to implement these procedures are to be made.

#### **3.6.6.7 – Reward Payment Audit Trail{tc "3.6.6.7 – Reward Payment Audit Trail" \l 4}**

The fraud unit must maintain an audit trail of the disbursed check. The following data should be included:

- Amount of the disbursed check;
- Date issued;
- Check number;
- Overpayment amount identified;
- Overpayment amount recovered;
- Social security number of complainant; and
- Party the complaint is against.

The fraud unit must update the IRP tracking database to reflect disbursement of the reward check to the complainant.

### **3.6.7 – HCFA Incentive Reward Winframe Database**

The IRP database was designed to track rewards that could be paid for information about fraud or abuse of the Medicare trust fund. Access to the IRP database is through the Winframe file server located at the HCFA data center and controlled through password and access codes. Cases can be entered into the IRP system by any Medicare fee for service contractor, managed care organization contractor, and the OIG. When the fraud unit refers a case to the OIG, they update the IRP system with all available information. The database contains the current status of all Medicare fraud/abuse cases pending reward. Some cases may be closed without a reward based on final disposition of the case. Medicare contractors and HCFA ROs have oversight responsibility for this system. The database provides the following information:

- On demand management reports;
- Duplicate complaints submitted for reward; and
- Audit trail of overpayments recovered as a result of the reward program.

The IRP database user instructions are found in Exhibit 5.3.

### **3.6.8 – Updating the Incentive Reward Database**

The contractor is responsible for updating the incentive reward database on overpayment recovery and reward amounts. Contractors must regularly follow up with the OIG to obtain information on recovery of complaints referred to them that originated from an IRP complainant. The contractor must follow up on referrals to the OIG when no action is taken within 90 calendar days. The tracking system database will be updated as information becomes available. Updates should be entered on a quarterly basis.

IRP screens may be viewed in Exhibit 5.9.

## **4 – Fraud and Abuse Alerts{tc "4 – Fraud and Abuse Alerts"}**

Fraud and abuse alerts are issued when there is a need to advise the carriers, intermediaries, PROs, providers, and beneficiary communities about an activity that resulted in the filing of false claims.

The alert describes the particular billing or merchandising practice or activity in enough detail to enable the contractor to determine whether the practice exists in its jurisdiction.

When one of these alerts is received, the contractor shall determine whether the scheme exists within its service area. If it does, contractors shall take appropriate action to protect the trust funds. Action may include denials, suspensions, overpayment recovery, and/or development of the case for referral to OIG/OI. In each case, whichever action the contractor takes must be based on findings developed independently of the alert. Once the alert has been investigated, report the results of the investigation to the RO (i.e., whether the scheme exists in the contractor's jurisdiction) and necessary steps that were taken to safeguard the Medicare trust funds.

### **4.1 – Types of Fraud Alerts{tc "4.1 – Types of Fraud Alerts" \l 2}**

There are two types of fraud alerts, National Medicare Fraud Alerts (NMFAs) and Restricted Medicare Fraud Alerts (RMFAs). These alerts are produced and distributed to those listed on the audience line on the appropriate HCFA letterhead. NMFAs are reproduced on blue border letterhead and RMFAs are reproduced on red border letterhead.

#### **A – NMFA**

The most commonly issued alert is the NMFA. These alerts do not identify specific providers or other entities suspected of committing fraud. They focus on a particular scheme or scam and are intended to serve as a fraud detection lead.

CO issues a NMFA when the fraudulent or abusive activity is perceived to be, or has the potential for being, widespread, i.e., crossing contractor jurisdictions. These alerts are numbered sequentially. Because HCFA and OIG use a comparable numbering system, HCFA alerts are identified either as HCFA NMFA, for unrestricted alerts, or for restricted alerts, HCFA RMFA, followed by the alert number appearing in the upper left hand corner. OIG alerts are identified by OIG, followed by the alert number appearing in parentheses at the bottom left hand corner. The MFISs distribute both OIG and HCFA alerts to all agencies in their jurisdiction within 15 working days of receipt by the contractor.

A NMFA contains the following disclaimer, in bold print:

**"This alert is provided for educational and informational purposes only. It is intended to assist interested parties in obtaining additional information concerning potential fraud and to alert affected parties to the nature of the suspected fraud. It is not intended to be used as a basis for denial of any claims or any adverse action against any provider or supplier. Such decisions must be made based on facts developed independent of this alert. This alert**

**is not intended to indicate, suggest, or imply that any particular individual or entity, or group of individuals or entities, are associated with the activity described herein."**

## **B – RMFA**

HCFA issues a restricted fraud alert when specific providers are identified as being suspected of engaging in fraudulent practices or activities. Contractors prepare this type of alert when advising other Medicare carriers, intermediaries, PROs, MFCUs, OIG, FBI, or DOJ of a particular provider or providers, suspected of fraud. Distribution is limited to Medicare contractors, HCFA, PROs, OIG/OI, FBI, MFCUs and the Offices of the U.S. Attorney. ROs will issue each MFIS one copy of a RMFA, which the contractor will reproduce on the red border letter provided to it. Contractors may issue local restricted alerts as they deem appropriate, subject to above distribution limits.

When sending a restricted fraud alert to CO, they should be mailed to:

Health Care Financing Administration  
Program Oversight Branch  
Mail Stop C3-02-16  
7500 Security Blvd.  
Baltimore, MD 21244  
Attention: FAC

The envelope should be marked, "personal and confidential", "do not open in mailroom". The content of this alert is not disclosable to the public even under the Freedom of Information Act. Public disclosure of information protected by the Privacy Act has serious legal consequences for the disclosing individual. It is intended solely for the use of those parties appearing on the audience line. It contains the names and other identifying information of providers or suppliers who are suspected of fraud.

A restricted fraud alert must contain the following disclaimer exactly as below:

**Notice: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT. ITS CONTENTS MAY NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT THE EXPRESS WRITTEN APPROVAL OF THE BENEFIT INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.**

## **C – Alerts to CO**

Contractors prepare one of these alerts when:

- Contractors need to notify HCFA of a scheme that is about to be publicized on the national media;
- The case involves patient abuse or large dollar amount (\$1 million or more); or

- The issues involved are politically sensitive, e.g., congressional hearings are planned to accept testimony on a fraudulent or abusive practice.

The alert is prepared and submitted in the same manner as a NMFA but the audience line reads, CO Only.

## 4.2 – Alert Specifications{tc "4.2 – Alert Specifications" \l 2}

Alerts drafted by the fraud unit must meet the following criteria:

- The alert is to be entitled, "National Medicare Fraud Alert," "Restricted Medicare Fraud Alert," or "HCFA CO Alert."
- It includes an audience line that indicates the audience that needs to be made aware;
- It has a subject line that briefly describes the issue or subject of the alert;
- The body of the alert describes the matter in enough detail to enable readers to determine their susceptibility to the activity and what they need to do to protect themselves. It includes diagnosis, Current Procedural Terminology (CPT), and HCPCS codes, as appropriate;
- It includes a discovery line that indicates how the contractor who initiated the alert discovered the problem (\*See note below.);
- It includes a detection methodology detailing the steps or approaches other contractors would use to determine whether this practice is occurring in their jurisdiction (\*See note below.);
- It includes the name and telephone number of a person or organization to be contacted in the event of a complaint or question; and
- It contains the appropriate disclaimer depending on the type of alert. CO alerts do not need a disclaimer.

**\*NOTE: DO NOT INCLUDE THE “DISCOVERY” AND “DETECTION METHODOLOGY” SECTIONS WHEN DISTRIBUTING AN ALERT TO A PROVIDER PROFESSIONAL ORGANIZATION OR OTHER OUTSIDE GROUP. THESE SECTIONS ARE DISCLOSABLE ONLY TO ROs, CONTRACTORS AND FEDERAL LAW ENFORCEMENT AGENCIES.**

## 4.3 – Editorial Requirements{tc "4.3 – Editorial Requirements" \l 2}

Contractors adhere to the following requirements when drafting a fraud alert:

- Avoid an emotional writing style such as frequent exclamation points, underlining, and bold type. State the issue in as matter-of-fact a way as possible;

- Avoid generalizing the problem to groups, specialties, or types of providers. Focus on the practice or issue;
- Do not state that performance of the activity is fraud even though the practice violates Medicare requirements. Couch the message in terms of "alleged," "suspected," "potential," "possible," "may be fraud";
- When stating applicable penalties, use "may" (e.g., "... may result in exclusion from the Medicare and Medicaid programs"). Do not state that certain penalties will be applied; and
- Avoid programmatic jargon or unnecessary terms of art. Use plain English, whenever possible, while remaining technically accurate. If technical terms are necessary, explain them.

Be certain the alert is technically accurate. Have it reviewed by the MFIS. Consult with RO and OIG, as necessary. Contacts with provider groups may be appropriate. Do not sacrifice technical accuracy in the interest of a speedy issuance or writing in plain English.

Issue alerts in Spanish or other appropriate foreign language if there is a non-English speaking population that is potentially affected by the scheme, and there are plans to distribute the alert to such groups.

#### **4.4 – Coordination**

Before preparing an alert, consult with the RO and MFIS. The MFIS knows whether or not a similar alert has been issued by contacting MFISs in contiguous jurisdictions. If so, use that alert and change the name and address of the contact to reflect the organization. If there is no such alert, forward the alert in draft to the RO. The RO forwards the draft to PI for review and clearance. Following its review, PI acknowledges the alert and notifies the contractor and the RO whether:

- A National alert will be issued;
- A restricted alert will be issued; or
- The alert should be issued as a local alert.

HCFA CO keeps the RO informed of the progress of the alert throughout the clearance process.

#### **4.5 – Distribution of Alerts**

HCFA issues the alert to the MFISs for further distribution. National alerts are sent to the MFIS through the electronic mail system. Upon receipt of an approved alert, the MFIS will change the name and telephone number appearing on the alert to their own name and telephone number. They will then reproduce the alert on their own stationary. MFISs are to distribute the alert to the entities that appear on the audience line and anyone else they deem necessary.

Both national alerts and a modified version of restricted alerts appear on HCFA's and OIG's web sites. The contractor may refer parties requesting copies of alerts to these web sites when appropriate.

Restricted alerts are mailed directly to the MFIS. When the MFIS distributes restricted alerts, the alert is to be delivered directly to the fraud unit manager and the outside of the envelope marked, **"DO NOT OPEN IN MAILROOM."**

## **5 – Referrals From Outside Sources**

Form SSA-3319, Referral of Potential Medicare Violation, is used by Social Security Administration Field Offices (SSA FOs) for transmitting a notice of potential Medicare program violations to contractors.

**NOTE:** The originating SSA FO may submit a written narrative in lieu of the SSA-3319. However, all information required by Form SSA-3319 is contained in the narrative. Subsequent processing remains the same.

SSA FOs complete the top portion of Form SSA-3319 and forward the original plus one copy to the contractor. They send a second copy of Form SSA-3319 (or narrative) to the RO, a third copy to the servicing OIG/OI, and keep a fourth copy for control and follow-up purposes.

Contractors advise the SSA FO of the status of the complaint upon request to enable the SSA FO to respond to inquiries from the beneficiary/complainant and forestall excessive inquiries to contractors.

Contractors send the SSA FO a completed copy of Form SSA-3319 or response to the narrative referral. They include a copy of the response sent to the complainant. If subsequent follow up is necessary, the SSA FO directs further inquiries to the contractor employee who certified the complaint as resolved.

Upon completing development, contractors notify the beneficiary/complainant of the results.

## **6 - OIG Referrals and Appropriate FID Entries**

The FID is a comprehensive nationwide on-line mainframe board system directed to fraud and abuse data accumulation.

The following agencies/organizations have access to the FID:

- Medicare Intermediaries and Carriers, including RHHIs and DMERCs;
- HCFA;
- FBI;
- DOJ;

- Office of United States Attorney Generals;
- HHS OIG;
- Department of Labor OIG;
- Defense Contractor Investigation Service;
- Postal Inspection Service;
- Tennessee Valley Authority Inspector General;
- Medicare Program Safeguard Contractors; and
- Medicaid Fraud Control Units.

Upon becoming operational, the FID will capture information on current cases that have been referred to the OIG. A case exists when the contractor has substantiated an allegation that a provider, beneficiary, supplier, or other subject: (a) engaged in improper billing, (b) submitted improper claims with actual knowledge of their falsity; or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. While substantiation does not imply the proving of the information in a court of law, the definition of “contractor substantiation” does include any and all cases (regardless of dollar threshold or subject matter) where contractor staff verify to their own satisfaction that an allegation is likely to be true and a referral to law enforcement is required subject to Program Memorandum (PM) AB-98-77. Situations where numerous complaints are made, allegations forwarded by provider employees or ex-employees, and/or proactive data analysis producing clear evidence of wrongdoing are common examples of such situations.

Alternatively, individual complaints (statements alleging improper entitlement), simple overpayment recoveries, and medical review abuses are not commonly considered “cases” for purposes of FID entry and are more appropriately documented in case control systems.

Finally, the term “substantiated” does not imply the proving of the information in a court of law. Contractors do not prove fraud and such action is within the purview of the Department of Justice.

Immediate advisements are excepted from the requirement of substantiation for purposes of advising OIG, and are not counted as referrals to the OIG.

The FID also reports other pertinent information. Some examples of the types of data included in the FID are:

- Subject of an investigation (i.e., hospital, SNF, HHA, Comprehensive Outpatient Rehabilitation Facility (CORF), etc.);
- Allegation information/nature of the scheme;
- Status of the case;

- Disposition of a case (i.e., administrative action, prosecution, exclusion, settlement, etc.); and
- Contact person.

The FID will also have monitoring/reporting capabilities such as:

- The number of cases by subject, sub-subject, region, contractor, HCPCS, etc.;
- Timely suspensions;
- Length of time to close out a case;
- Number of cases referred to OIG/FBI;
- Number of cases accepted by OIG/FBI;
- Number of cases sent back for additional development; and
- Dollar amount recovered through settlement, suspensions, and recoveries other than case settlements.

Open or pending cases with the OIG as of 1/1/93, which involve contractor-substantiated allegations of fraud, should be entered into the FID and referred to law enforcement within 30 days of identification. (Note: All "substantiated" cases are now referred to the OIG per PM AB-98-77).

The narrative section on the FID (F5 key) should clearly identify any case development being done by the contractor. Also, the sooner a comprehensive case is entered into FID, the more efficiently other contractors, HCFA, and law enforcement agencies can react to the investigation.

The contractor should enter cases that are initiated and referred by law enforcement into the FID within 30 days once law enforcement gives their approval. Absent their objections, and with their input, the case should go in the FID. However, the entry should be clear that the "case" came from law enforcement, not the contractor, and should not be counted as a contractor referral. Contractors should enter as much information as possible, and in their possession. This instruction is given with the understanding that the case did not result from contractor action and the realization that the contractor may not have information for some/many data fields.

In addition to contacting OIG regarding the status of a case, there is a need for the contractor to actively keep track of his or her referral(s). This means that FID entries should address:

- Contacting the FBI or Assistant United States Attorney (AUSA) regarding their actions on case;
- Updating the action screen to capture subsequent law enforcement referrals;

- Keeping apprised of MR/Provider Audit and Reimbursement actions if they are taking actions on a case;
- Updating the amount being withheld, denied, or paid;
- Entering information on convictions /sentences in the action screen; and;
- Revising the narrative screens to incorporate any updated information from the action screens.

If problems are encountered which undermine these activities, they should be discussed with BI staff from the HCFA RO. The contractor should document all major actions taken in the Action/Disposition screen (e.g., overpayment calculated, payment suspension imposed, prepay initiated/removed, etc.).

Cases must be updated every 30 days if the case has not been referred to law enforcement and every 90 days once it has been referred.

Cases can be deleted from the FID only by users with the "File Manager" (system administrator) designation. As applicable and necessary, HCFA CO and RO staff will contact and discuss with the contractor the need to correct and/or delete a case from the database. In the event that a contractor decides that a case should be deleted from the FID, this information should be forwarded to the HCFA RO, HCFA CO FID contacts, or BI Coordinator for approval.

A duplicate case exists when any given contractor enters a provider, supplier, or beneficiary as the subject of an investigation more than once, absent different allegations or other differentiating criteria requiring a separate referral.

Cases that are being worked by multiple contractors should be entered only once by the original contractor. However, if the original case results in a spin-off case, where another contractor makes an independent referral to law enforcement for a separate and distinct allegation of fraud, then a new case should be separately entered into the FID.

If a case is being developed on a provider already the subject of any closed case, a new case should be opened, but the closed case should be mentioned in the case narrative screen and cross-referenced to the old FID case number.

The case target, whether entity or individual, should be entered as the subject of the FID case. Any and all related providers, suppliers, or beneficiaries, who are a subject of the case, should then be identified under AKAs, DBAs, and Affiliates. However, if the individuals are the primary subjects/targets of the investigation and independent cases are made against them, then individual cases should be established in the FID with corresponding individual referrals to OIG.

It is the contractor BI unit's responsibility to check for potential duplicate entries of FID cases.

In this example the FID should include cases on both the HHA and the physical therapist. The HHA is accountable for ensuring that all services billed to them are correct and reimbursable and therefore at fault for services billed but not rendered by the physical therapist in their employ. The physical therapist is responsible for the services billed but not rendered, and is therefore

accountable for causing false claims to be submitted to Medicare. Finally, it is the contractor's responsibility to check for potential duplicate entries of FID cases.

Under the redesigned FID, a separate data field is contained for "Estimated Overpayment". Redesigned action screens also record "Overpayment Assessed" and "Overpayment Recouped". However, until such time as the redesigned FID is released, the contractor should enter the best estimate of the overpayment figure. As the substantiated allegation progresses as a case, the contractor will replace the estimated loss with the actual loss. If the overpayment is recovered before the case is closed, the amount recovered should be entered in this space, and in addition, should be captured as an "action". If the recovery occurs after the case is closed, the contractor must still update the FID with the recovered amount, updating both the "estimated overpayment" and "action" fields.

In addition to the referral of cases to the OIG, contractors should identify and take corrective action to prevent future improper payment (for example, by denying false claims, placing the provider or suppliers' claims on pre-payment review, post-pay review, payment suspension, or CMPs). The contractor should take all appropriate action in order to prevent any further payment of inappropriate claims and to recover any overpayments that may have already been made, regardless of whether the OIG/FBI accepts or declines the case referral.

That being said, appropriate action varies from case to case. In one instance, it may be appropriate to suspend payment pending further development of the case and calculation of an overpayment. In another instance, suspending payment may alert the provider to detection of the fraudulent activity and undermine a covert operation already underway, or actively being planned, by Federal law enforcement.

To be certain that the contractor intervention matches the alleged situation, it is important to consult with the HCFA RO, and as applicable (e.g., when law enforcement has an open investigation), the OIG, FBI, and both the civil and criminal divisions in the U.S. Attorney's office, before implementing payment suspensions, overpayment recoveries, etc. Where there is reliable evidence of fraud and a law enforcement referral pending, or already made, the contractor must advise the HCFA RO and the agency that has the lead for the investigation prior to initiating the administrative action.

It is extremely important to document in the FID any consultations with law enforcement as well as administrative actions and associated monetary assessments by the contractor. Contractors are responsible for providing such documentation.

It is not appropriate for an OIG or FBI Agent, or an AUSA to request that a contractor not enter a contractor developed case, or update the FID on a related contractor developed case. Contractors should inform law enforcement agents making such requests that you are required by HCFA to maintain the FID and that you do not have the discretion to do otherwise. Further, advise them to contact the HCFA RO or their headquarters if the matter persists.

Should you become aware of any sensitive undercover law enforcement information (e.g., on-going video surveillance, a planned raid by law enforcement, outstanding arrest warrants, etc.), this should not be entered in the FID, unless, after the fact and approved by the applicable OIG/FBI case agent. Also, do not enter the names of agents in the case description field. This information belongs in the "contact" portion of the case screens.

All cases where the allegations of fraud have been substantiated should be referred to the OIG. The OIG has 90 calendar days to accept the referral, return the case for additional development, or decline the case. Acceptance or rejection of the referral, like all other significant contacts with the OIG, should be documented in the FID.

It is the contractors' responsibility to follow up with the OIG and HCFA RO on cases to assure that the referrals are not held for an extended time without action. If the OIG does not respond to the contractor within the 90-day time frame, the contractor should follow-up with OIG/OI to determine if they are going to accept the case. If the 90 days have been exceeded with no decision from the OIG, then the contractor should attempt one more contact with the OIG to render a decision.

If within a specified and reasonable time period (e.g., give business days) the OIG does not accept the case or is still unwilling to render a decision on the case, contractors should proceed with administrative action necessary to ensure the integrity of the Medicare Trust Funds. In all cases, contractors should institute all appropriate remedies available to them (e.g., overpayment recoupment, suspension, prepay review) and inform their respective regional office of their decision to proceed with administrative actions. Contractors should always develop and initiate appropriate administrative action prior to the elapsing of the 90 days and inform OIG of this proposed action prior to implementing the remedy.

Referrals accepted by OIG or FBI, are assigned an OIG/FBI case number. The OIG/FBI have the ability to enter the case number in the FID on cases initiated by the contractor. If the applicable law enforcement agency is unable to manually enter the case number, the contractor is expected to obtain and enter the case number.

The contractor should revise information in the FID action field after the case is referred to the OIG/FBI. Any actions taken by law enforcement, (e.g., indictments, searches and seizures, warrants) as well as contractor corrective/administrative actions should all be entered into the FID. If the contractor is not able to obtain status on cases referred to law enforcement, this should be brought to the attention of the HCFA RO and/or HCFA CO.

To restate, Medicare fraud unit managers need to ensure that their referrals are handled according to OIG procedures (i.e., the referral is reviewed, accepted or rejected, or referred to another law enforcement agency within 90 calendar days of the referral). It is the contractors' responsibility to follow up on cases to assure that the referrals are not held for an extended period without action.

Under current manual guidelines, the contractor should immediately "advise" OIG when allegations concerning one or more of the characteristics listed below are received:

- Indications of contractor employee fraud (e.g., altering claims data or manipulating it to create a payment preferential treatment to certain providers; preferential treatment in collection of overpayments; embezzlement).
- Current provider employee who personally calls or visits the contractor and has information or evidence fraud is currently ongoing. Notification to Law Enforcement should be at the time of the occurrence whenever possible; Allegations of kickbacks, bribes.

- A crime by a Federal employee.

When an immediate "advisement" is required, all available information must be forwarded, unless otherwise directed by OIG. However, the initial forwarding of the applicable information does not equate to the contractor completing the full referral "package" as defined in the PIM, and does not equate to a case referral to law enforcement. Do not enter the information into the FID, unless directed to do so by the OIG.

The "case" information is to be entered into the FID concurrent with, or within 30 days after, the "advisement" if the contractor substantiates the allegation, or upon such time the OIG accepts the "advisement" and opens a case.

Contractors should not expend resources attempting to substantiate the allegation until so directed by HCFA and/or the OIG. For example, if a contractor receives an allegation of kickbacks, the contractor should immediately advise the OIG of the allegation, but not initiate an independent contractor query until requested to do so by the OIG and guidance on the parameters of the query are provided by the OIG. In this example, HCFA nor its contractors have the authority (jurisdiction) to investigate allegations & kickbacks, thus "immediate advisement" to OIG.

When the OIG formally declines a referral, the contractor is free to refer the case to another law enforcement agency (e.g., FBI, Postal, IRS, etc.). However, when this occurs, it is considered an update reflecting a subsequent action, not a new referral to law enforcement. As a general rule, subsequent referrals to other law enforcement agencies do not count as new case entries in the FID, nor are they counted for workload purposes as new referrals to law enforcement.

MFISs receive training on how to input and maintain cases in the FID. The intent is to use MFISs as "FID experts" and points of contact for questions and comments on the FID. The MFISs should be responsive to FID questions from carriers and intermediaries and law enforcement personnel within their jurisdiction.

MFISs should regularly share FID information and analysis (e.g., FID system reports) with the fraud unit manager, or their designee, for their applicable jurisdiction. The MFIS serves as a resource to HCFA on the FID including FID training. While the MFIS should not enter cases into the FID or monitor FID quality, if the MFIS detects any inaccuracies or indiscrepancies they should notify the respective contractor staff and/or management. Upon request, the MFIS will furnish FID reports to the BI unit manager within their jurisdiction. (Refer to PM AB-00-50).

The contractor's usage of the FID is evaluated during CPE reviews. Areas evaluated include the timeliness, accuracy, and completeness of information entry. For example, during the evaluations, the FID will be reviewed to ensure that all appropriate cases are entered and updated on a timely basis and all applicable actions (e.g., OIG referral, overpayment identification, etc.) are completely accounted.

If you have never applied to access to the FID system and require authorization, an "Application for Access to HCFA Computer Systems" must be completed, submitted and approved. This form may be acquired from: (1) the appropriate RACF Group Administrator (see attachment) for all HCFA central and regional office and contract users, or (2) Scott Manley (410) 786-7146 or

Scott Wakefield (410) 786-4301 in the HCFA Division of Program Integrity Operations for all law enforcement personnel or other users.

For those individuals who have received prior authorization, but are experiencing authorization lapses or password problems, the same contacts referenced above should be contacted. Internet access problems are appropriately directed to Gail Diepold (410) 786-6341 or Nancy Peschau (410) 786-6008 at HCFA Central Office while software or other connection problems are handled by the HCFA Action Desk at (410) 786-2580.

Persistent problems or instances where corrective actions cannot be made, should be forwarded to Mark Koepke (410) 786-0524 in the HCFA Division of Program Integrity Operations. Mr. Koepke is also the direct point of contact for special extracts and reporting options as well as access submissions of “nonstandard” users.

## Medicare Program Integrity Manual

### Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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# **1 – Introduction{tc "1 – Introduction"}**

Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. MR staff should not expend resources analyzing provider compliance with other Medicare rules (such as claims processing rules, conditions of participation, etc.). If during a review it is determined that a provider does not comply with conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency. The overall goal of taking administrative action should be to correct the behavior in need of change, to collect overpayments once identified, and deny payment when payment should not be made. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action should

be initiated. In every instance, the contractor's priority is to minimize the potential or actual loss to the Medicare Trust Funds while using resources efficiently and treating providers and beneficiaries fairly.

A variety of interventions may be necessary in order to correct inappropriate behaviors. Contractors should use feedback and/or education as part of their intervention. Contractors should make sure that administrative actions are commensurate with the seriousness of the problem identified, after a limited probe is done to understand the nature and extent of the problem. Serious problems should be dealt with using the most substantial administrative actions available, such as 100 percent prepayment review, payment suspension, and review of a statistically valid random sample (SVRS) of claims. Small and isolated problems should be dealt with through feedback and reevaluation after education. At any time, evidence of fraud should result in referral to the fraud unit for development.

### **1.1 – Provider Tracking System (PTS)**

Carriers must have in place a PTS. All FIs must have such a system in place by January 1, 2002. The PTS will identify all individual providers and track all contacts made as a result of actions to correct identified problems such as eligibility and medical necessity issues and repeated billing abusers who frequently change the way they code their bills to their financial advantage. Contractors should use the PTS to coordinate contacts with providers (e.g., MR education contacts). Contractors should ensure that if a provider is to be contacted as a result of more than one problem, multiple contacts are necessary, timely and appropriate, not redundant. Contractors should also coordinate this information with their fraud unit to assure contacts are not in conflict with fraud related activities. The PTS should contain the date a provider is put on a provider specific edit. The contractor should reassess all providers on MR quarterly to determine whether the behavior has changed. The contractor must note the results of the quarterly assessment in the PTS. If the behavior has resolved sufficiently and the edit was turned off, note the date the edit was turned off in the PTS. When a provider appeals a medical review determination to the ALJ, the information in the PTS should be shared with the ALJ to demonstrate corrective actions have been taken by the contractor.

### **1.2 – Evaluating Effectiveness of Corrective Actions**

Contractors must evaluate the effectiveness of their corrective actions on targeted problem areas at least every 3 months until there is evidence that the problem is corrected. Contractors must use the PTS for anyone in their organization who provides education and other contacts with providers. Contractors must use the PTS to coordinate contacts with providers (e.g. MR education contacts). Contractors must ensure that, if a provider is to be contacted as a result of more than one problem, multiple contacts are necessary, timely and appropriate, not redundant. Contractors must also coordinate this information with their fraud unit to assure contacts are not in conflict with fraud related activities.

## **2 – Verifying Potential Error and Setting Priorities**

Understanding the characteristics of the service area of the provider is a key element of claim data analysis. The areas selected for review by the contractor (e.g., providers, services) must be significant and contractors must be able to document the rationale for selection. Using claims data, contractors shall determine the degree to which a potential error is widespread and decide if the potential error meets the deviation indicators established. When services and/or providers appear outside of norms, the contractor must verify that the potential error represents an unacceptable practice. Further investigate the provider(s) identified as causing the potential error.

Some examples of possible legitimate explanations for potential error are listed below. This is not an all-inclusive list.

- The provider may be associated with a medical school, research center, or may be a highly specialized facility; and
- The community may have special characteristics such as economic level or a concentration of a specific age group that leads to the aberrancy;

## **A – Error Validation Review**

If no legitimate explanation exists for the potential error, the contractor should verify the cause of a potential error. The contractor shall not suspend large volumes of claims for review or use 100% prepayment review. Instead, the contractor shall select a sample of cases which is representative of the universe where the problem is occurring. The contractor shall request appropriate medical documentation and review cases for coverage and correct coding. MR staff should not be reviewing claims for compliance with other Medicare rules (i.e., claims processing, conditions of participation, etc.). Error validation reviews may be conducted on a prepayment or postpayment basis.

Where errors are verified, the contractor shall initiate appropriate corrective actions found in PIM Chapter 3, §§5, 6, and 8 through 12.

Where no corrective action is taken, the contractor must document findings and explanations for not pursuing the problem. If no problems are found, the contractor shall discontinue the review. Do not wait until the end of the quarterly reporting period to end the review process.

In all situations where errors have been verified, the MR unit must notify the provider (written or verbal) that the particular practice or behavior is inappropriate and should not continue.

Error validation reviews require the examination of the provider's medical documentation but does not require SVRS methodologies. It does not allow projection of overpayments to the universe of claims reviewed. In this type of review, contractors collect overpayments only on claims that are actually reviewed, determined to be non-covered or incorrectly coded, and the provider is liable or at fault for the overpayment.

It may be used to determine:

- The extent of a problem across multiple providers, or
- Whether an individual provider has a problem.

Contractors shall select providers for Error Validation Reviews for the following but are not limited to:

- The contractor has identified questionable billing practices, ( i.e., noncovered or incorrectly coded services) through data analysis.
- Alerts from other intermediaries, carriers, PROs, intermediary payment staff, or other internal components are received that warrant such review;
- Complaints.

Contractors must document their reasons for selecting the provider for the Error validation review. In all cases, they must clearly document the issues cited and the applicable law or their published national coverage policies or local medical review policy.

Contractors select a minimum of 30 claims for review, and generally limit the review to claims processed within the most recent year.

## **B – Setting Priorities**

Contractors must focus administrative resources to achieve the greatest dollars returned to the Medicare program for resources used. This requires establishing a priority setting process to assure MR is focused on areas with the greatest potential for abuse. Abuse may be demonstrated by high dollar payments, high volume of services, dramatic changes, or significant risk for negative impact on beneficiaries (e.g., low volume but unnecessary surgery).

Efforts to stem errors must be targeted to those areas which pose the greatest financial risk to the Medicare program and which represent the best investment of resources. Contractors should focus where the services billed have significant potential to be noncovered, incorrectly coded, or misrepresented. Target areas may be selected because of:

- High volume;
- High cost;
- Dramatic change;
- Adverse impact on beneficiaries; and/or
- Problems which, if not addressed, may escalate.

Contractors have the authority to review any claim at any time, however, the claims volume of the Medicare program prohibits review of every claim. Resources dictate that in attempting to make only correct payments, contractors make deliberate decisions on the best uses of limited resources to maximize returns. For example, contractors may decide not to review claims for certain services or providers for extended periods of time. Medical review staff may decide to focus review on problem areas that demonstrate significant risk to the Medicare program as a

result of inappropriate or potentially inappropriate payments. Contractors must have in place a program of innovative, systematic, and ongoing analysis of claims and other relevant data to focus intervention efforts on the most significant errors.

## **2.1 – Determining Whether the Problem is Widespread or Provider Specific**

**For each verified, priority problem, the contractor must determine whether the problem is widespread or provider specific. If the error is a widespread problem and evenly distributed among providers, contractors should validate the concern by review of 100 potential problem claims from a representative sample of providers--prepay or postpay and deny or collect money as appropriate. Take service-specific corrective actions:**

- **Contact medical and specialty societies to assist in education; and**
- Develop new/revised LMRPs if needed; and/or
- Issue bulletin article clarifying rules; and/or
- Initiate service-specific prepay edits.

If the error is limited to a small number of providers, contractors should validate the concern by review of 20-40 potential problem claims for each provider in question—prepay and postpay and deny or collect money as appropriate.

## **3 – Provider Education**

### **A – Widespread Provider Education**

Issuing a provider bulletin as an educational tool may be helpful if a problem is general or widespread.

### **B – Focused Provider Education**

In addition to the MIP-PET activities identified in Chapter 1, §5, contractors must initiate focused provider education when a specific error is verified. Focused provider education means direct 1-to-1 contact between the contractors and the provider through a telephone contact, letter, or meeting. When individual providers are contacted, contractors must provide comparative data on how the provider varies significantly from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the perceived problem more clearly. Contractors are encouraged to have contact with providers to make them aware that they have noticed unusual patterns and to gather information. Contact may be in the form of telephone calls, written correspondence or an informal in-person meeting. Contractors must deny non-covered and incorrectly coded services even while provider education is occurring. Reviews of applicable LMRPs with providers may be useful to emphasize the contractors' point.

### **3.1 – Provider Contacts By the Fraud Unit**

A fraud unit may determine that the resolution of a case does not warrant referral for criminal, CMP, or sanction and that a meeting with the provider is more appropriate. The contractor must inform the provider of questionable or improper practices, the correct procedure to be followed, and that continuation of the improper practice may result in administrative sanctions. The contractor shall document contacts and/or warnings with written reports and correspondence and place them in the complaint file. If the improper practices continue, the contractor consults with the OIG/OI contact person regarding sanction action.

If the provider continues aberrant billing practices during the period for which it is being investigated for possible sanction, the contractor shall adjust payments accordingly. After meeting with a provider, the contractor must prepare a detailed report for the case file and forward a copy to OIG/OI, if requested. The report must include the information in A, B and C below.

#### **A – Background of Provider (Specialty)**

Contractors must include a list of all enterprises in which the subject had affiliations, the states where the provider is licensed, all past complaints, and all prior educational contacts/notices.

#### **B – Total Medicare Earnings**

Contractors include a report of the total Medicare earnings for the past 12 months as well as total dollars for assigned and non-assigned claims in that period in the case file.

The report includes the following:

- Earnings for the procedures or services in question;
- Frequency of billing for these procedures/services; and
- Total number of claims submitted for these procedures/services.

#### **C – Extent of Audit Performed**

Contractors include:

- A report of your audit process and findings;
- Overpayment identified; and
- Recommendation(s).

### **4 – Overview of Prepayment and Postpayment Review**

When contractors review claims, either on a prepayment or postpayment basis, they shall make a coverage determination and a coding determination. Contractors must be able to differentiate the type of denial to ensure that limitation on liability determinations are made when appropriate.

Contractors must deny payment either partially or in full whenever there is evidence that an item or service:

- Does not meet the Benefit Category requirements described in Title XVIII of the Act and national coverage policy;
- Is statutorily excluded by sections §§1862(a)(1)(B)-(F), 1862(a)(2)-(15) and 1862(c)-(h) of the ACT;
- Is not reasonable and necessary as defined under §1862(a)(1)(A) of the Act;
- Was not billed in compliance with the national and local coding requirements;
- Was not rendered (or was not rendered as billed);
- Required additional documentation and the provider failed to submit solicited documentation;
- Was furnished in violation of the self-referral prohibition; or
- Was furnished, ordered or prescribed on or after the effective date of exclusion by a provider excluded from the Medicare program and that provider does not meet the exceptions identified below in PIM Chapter 3, §11.2.6.

For reporting purposes, contractors need to differentiate automated versus manual prepayment review of claims. Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied.

In accordance with §1879 of the Act, contractors first consider coverage determinations based on the absence of a benefit category or based on statutory exclusion. If both these conditions are met, the next consideration should be whether the service was reasonable and necessary. If a reasonable and necessary denial is made, contractors must then make a limitation of liability determination (see §§1879, 1870 and §1842(L) of the Act).

Limitation of Liability determinations do not apply to denials based on determinations other than reasonable and necessary.

Contractors must deny payment whenever there is evidence that an item or service was not furnished, or not furnished as billed even while developing the case for referral to OIG or if the case has been accepted by the OIG. Before denying payments, contractors must consult with the RO. In cases where there is apparent fraud, but the case has been refused by law enforcement, contractors deny the claim(s) and collect the overpayment. It is necessary to document each denial thoroughly to sustain denials in the appeals process. Intermediaries must make adjustments in cost reports, as appropriate.

Denials are appropriate when additional documentation of medical necessity (e.g., original certificates of medical necessity where the contractor suspects alteration) is requested and the provider/supplier fails to submit it. In this situation, the limitation of liability determination is that the provider is held liable for the denied services including any applicable deductible or coinsurance amounts. Denials are also appropriate if it is determined that services were furnished in violation of the self-referral prohibition.

Contractors do not make payment for items or services furnished, ordered, or prescribed by any excluded provider on or after the effective date of exclusion, except in the cases listed below:

- In the case of inpatient hospital services or post-hospital SNF care provided to an individual admitted to a hospital or SNF before the effective date of the exclusion, make payment, if appropriate, for up to 30 days after that date; and
- In the case of home health services provided under a plan established before the effective date of exclusion, make payment, if appropriate, for the duration of the current episode.

Payment may be made to an excluded provider for **emergency** items and services furnished, ordered or prescribed (other than an emergency item or service furnished, ordered or prescribed in a hospital emergency room) on or after the effective date of exclusion.

If claims are submitted after the effective date of the exclusion by a beneficiary for items or services furnished, ordered, or prescribed by an excluded provider, contractors:

- Pay the first claim submitted by the beneficiary and immediately give notice of the exclusion; and
- Do not pay the beneficiary for items or services provided by an excluded party more than 15 days after the date of the notice to the beneficiary or after the effective date of the exclusion, whichever is later. The regulatory time frame is 15 days, however, HCFA allows an additional five days for mailing.

If claims are submitted by a laboratory or DME company, for any items or services ordered by a provider excluded under §1156 (Title XVIII of the Act), or any items or services ordered or prescribed by a physician excluded under §1128 (Title XVIII of the Act), handle the claims as above.

See PIM Exhibit 13.1.

For each claim denied, contractors must carefully document the basis for the denial in the file (postpay MR, fraud) or audit trail (prepay MR). If there are several reasons for denial, state and document each basis. If there are questions concerning the adequacy and legal sufficiency of the documentation, discuss the rationales with the RO.

In establishing an overpayment, contractors carefully document claims for items/services not furnished or not furnished as billed so that the denials are more likely to be sustained upon administrative appeal and potential judicial review. They obtain and include signed, dated, and sworn statements by beneficiaries and other corroborative evidence, as may be available, in the

file for the hearing officer's and ALJ's review. The following statement is sufficient. "I declare under penalty of perjury that the foregoing is true and correct."

Section 1862(a)(1) of the Act is the authority for denial because a service is not reasonable and necessary. When a claim is denied, in full or in part, because an item or service is not reasonable and necessary, contractors make and document §§1879, 1870, and 1842(l) (limitation of liability) determinations as appropriate. Because these determinations can be appealed, it is important that the rationale for the determination be documented both initially and at each level of appeal. Also contractors include a copy of the LMRP which shows the basis for their determination in the case file.

## **5 – Prepayment Review of Selected Claims**

Prepayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made before claim payment.

Prepayment claims review allows the contractor the opportunity to make a determination to either pay a claim in full, in part, or to deny payment. This process requires the application of clinical expertise or the use of internal MR guidelines based on clinical expertise.

Prepayment review occurs when computer edits specified by the contractor identify and/or suspend claims for closer scrutiny. The edits should be specific enough to identify only those claims that the contractor determines to be questionable. Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The MR unit should establish and modify edits on an ongoing basis, as necessary. When evaluating these edits, consider appeals information.

### **5.1 – Automated and Manual Prepayment Review**

When prepayment review is fully automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. Fully automated review never results in claim suspension for manual review. Partially automated review, however, is somewhat automated but may result in suspending claims for manual review. When appropriately implemented, fully automated review increases efficiency and consistency of decisions. Contractors must implement fully automated prepayment review whenever appropriate.

Fully automated review must have clear written NCP or LMRP that serves as the basis for denial. In those instances where prepayment review is fully or partially automated, the LMRP or national policy must clearly list the circumstances under which a service will be denied. Also, services that are specifically excluded by statute or that national policy states are never reasonable and necessary can be automatically reviewed and need not be manually reviewed before denial. (See PIM Chapter 3, §5) When a NCP or LMRP clearly indicates that under certain circumstances a service is NEVER covered, contractors may automatically deny the services under those circumstances without stopping the claim for manual review, even if documentation is attached. Reviewers must still make a §1879 limitation of liability determination that may require manual review.

Contractors shall not deny services that exceed utilization parameters without reviewing all relevant information submitted with the claim (e.g., justifications prepared by providers, primary and secondary diagnoses, and/or medical records), except in the instance of egregious abuse. In those circumstances, services may be automatically denied.

Manual prepayment review requires the intervention of health care professionals or specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be referred for manual review because a MR determination cannot be made based on the available electronic information and is, therefore, suspended for evaluation by the MR review staff. When necessary, contractors shall use physician consultants and other health professionals to review claims and medical documentation. The consultant's decision must be based on the relevant national coverage policy and/or LMRP in effect at the times of services.

### **5.1.1 – Prepayment Edits**

Prepayment edits are designed by contractor staff and put in place to prevent payment for noncovered and/or incorrectly coded services and to select targeted claims for review prior to payment. More specifically, MR edit development is the creation of logic (the edit) that is used during claims processing prior to payment that validates and/or compares data elements on the claim.

Contractors must focus edits, to the extent possible, to suspend only those claims with the greatest likelihood of being denied and avoid suspending claims of providers who have not contributed to the problem. Focusing edits to target claims minimizes inefficient review and provider hassle. Prepayment edits must be able to key on a beneficiary's Health Insurance Claim Number (HICN), a provider's identification (e.g., Provider Identification Number (PIN), UPIN) and specialty, service dates, and medical code(s) (i.e., HCPCS and/or ICD-9 diagnoses codes). Intermediary edits must also key on Type Of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

Carrier systems must be able to perform several comparisons to select claims for prepayment review. By January 2001, FI systems must be able to perform these comparisons as well. At a minimum, those comparisons must include:

- Procedure to Procedure – This relationship permits contractor systems to screen multiple services at the claim level and in history.
- Procedure to Provider – For a given provider, this permits selective screening of services that need review.
- Frequency to Time – This allows contractors to screen for a certain number of services provided within a given time period.
- Diagnosis to Procedure – This allows contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin B12 injection is related to pernicious anemia, absence of the stomach, or distal ileum.

- Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.
- Procedure to Specialty Code (Carrier) or TOB (Intermediary) – This permits contractors to screen services provided by a certain specialty or type of bill.
- Procedure to Place of Service – This allows selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Examples of intermediary edits include, but are not limited to, the following:

- Diagnoses alone or in combination with related factors, e.g., all ICD-9-CM codes XXX.X-XXX.X with revenue code (REV) XXX and units greater than X;
- Revenue and/or HCPCS codes, e.g., a REV with a selected HCPCS (REV XXX with HCPCS XXXXX);
- Charges related to utilization, e.g., an established dollar limit for specific REV or HCPCS (REV XXX with HCPCS XXXXX with charges over \$500);
- Length of stay or number of visits, e.g., a selected service or a group of services occurring during a designated time period (bill type XXX with covered days/visits exceeding XX); and
- Specific providers alone or in combination with other parameters (provider XX-XXXX with charges for REV XXX).

Contractors should **always** seek to implement prepayment edits that will prevent payment of services to providers billing egregious amounts and/or to providers with a pattern of billing for services that are not covered. When contractors identify egregious overutilization, they must respond timely, even though the egregious overutilization may not be addressed by either national and/or LMRPs.

When egregious levels of utilization are identified, contractors may automatically deny the entire line item as not reasonable and necessary if the units and/or dollar parameters meet the definition of an egregious level. Egregious level is defined as a level of utilization for that service(s) which far exceeds what would generally be expected. This level must be based on information gathered from claims processing history and/or informal discussions with the appropriate clinical community. Contractors must quickly establish edits when egregious levels of utilization are identified.

#### **5.1.1.1 – Evaluation of Prepayment Edits**

The contractor must evaluate all service specific and provider specific prepayment edits quarterly. The purpose of this evaluation is to determine their continuing effectiveness and contribution to workload. Contractors shall consider an edit to be effective when an edit has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of

operation or potential to avoid significant risk to beneficiaries. Revise or replace edits that are determined to be ineffective. Edits may be ineffective when a large volume of claims are suspended for review and there are few or no denials. Edits may also be ineffective when payments denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, if a measurable impact is expected, or if a quarter is too short for change to occur. Contractors should analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. Contractors should replace, if appropriate, existing effective edits to address problems that are potentially more costly.

Listed below are factors to consider in looking at edit effectiveness:

- Number of claims/days/charges reviewed in comparison to claims/days/charges denied;
- Time and staff needed for review compared to dollars saved;
- Specificity of edits in relation to identified problem(s);
- Demonstrated change in provider behavior, e.g., the contractor can show the decrease in frequency of services per beneficiary, the decrease in the number of beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;
- Impact of educational or deterrent effect in relation to review costs; and
- The presence of more costly problems identified in data analysis that needs higher priority than existing edits.

Contractors must test each edit before implementation to determine the impact on workload and whether the edit accomplishes the objective of efficiently selecting claims for review.

Contractors must develop edits for new providers and for new benefits to ensure correct coverage and coding from the beginning.

**Note:** While program savings are realized through denials for inappropriate provider billing, the optimal result occurs when providers no longer bill for non-covered or incorrectly coded services.

## **5.2 – Categories of MR Edits**

For reporting purposes, there are three kinds of prepayment edits:

### **A – Service-Specific Edits**

These are edits that select claims for specific services for review. They may compare two or more data elements present on the same claim (e.g., diagnosis to procedure code), or they could compare one or more data elements on a claim with data from the beneficiary's history file (e.g., procedure code compared to history file to determine frequency in past 12 months).

## **B – Provider-Specific System Edits**

These are edits that select claims from specific providers flagged for review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits can suspend all claims from a particular provider or focus on selected services, place of service, etc. (e.g., all claims for holter monitoring from a given provider).

## **C – Random Edits**

Because it is important to have the flexibility to modify MR edits based on workload demands and changes in provider behavior, contractors are encouraged to ensure that all MR edits are located in the table driven portion of the system and are not hard coded.

### **5.3 – Documentation Specifications for Areas Selected for Medical Review**

Providers selected for review are responsible for submitting medical records requested by the servicing contractor within established timeframes.

#### **5.3.1 – Laboratory Claims**

In performing MR, contractors must deny claims for any tests for which a laboratory cannot provide adequate information to support payment. Generally, reviewers may assume the medical necessity of a laboratory test if there is documentation that each test performed was individually ordered by a physician. This includes claims for automated chemistry profiles where documentation includes evidence that each test is ordered individually (i.e., not ordered as part of a profile or custom panel).

For these purposes, an order for a disease or organ panel (as defined in the CPT - Fourth Edition (CPT-4)) is considered an individually ordered test. Medical necessity can be reevaluated if an aberrant pattern of utilization is uncovered. In such cases, additional information can be required. (See PIM Chapter 3, §5.3.3)

Where laboratory tests are not **ordered individually** (i.e., these are ordered in an automated profile or custom panel), a determination of whether a test is reasonable and necessary should include consideration of:

- Whether the test provides additional needed information;
- Whether the information could be obtained through another test which has a lower price; and
- Whether the test is ordered at an unusually high frequency.

Each of the tests ordered must be reasonable and necessary. Follow-up tests repeated because of compromised specimens, inadequate specimens, incorrect specimens, or incorrect test ordering

should be denied unless adequate documentation is provided to justify payment. The laboratory must explain why follow-up tests are repeated.

### **5.3.2 – Documentation for Non-physician Claims**

Section 1833(e) of the Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person . . ." Contractors may require information, such as diagnosis, necessary to determine whether an item or service is covered and reasonable and thus to determine appropriate payment.

In order to address potential abuse or overutilization, contractors can require that diagnosis information be submitted with each claim for the targeted service (e.g., all laboratories must submit diagnosis information with all claims for a specific HCPCS code). This information is used in determining the medical necessity of the service. Requiring diagnosis information to be submitted by all non-physician billers with every claim for a targeted service must be part of a LMRP.

For individual non-physician providers who are identified due to unusual billing practices, fraud referrals, etc., contractors may also request diagnosis information to support the medical necessity of all or some claims submitted by the targeted entities.

In both cases, while contractors may encourage the submission of ICD-9 codes on a claim, contractors must allow for the submission of a narrative description. Claims submitted without sufficient evidence can be denied as being not reasonable and necessary.

### **5.3.3 – Development of Claims for Additional Documentation**

When intermediaries cannot make a determination of medical necessity based upon the information on the claim and its attachments, they:

- Request additional documentation;
- Pend the claims for 35 days;
- Deny the claim for lack of medical necessity if the information is not received within 35 days after the date of the request. This allows 5 days mail time;
- For SNFs, HHAs, hospitals and hospices, intermediaries shall hold the provider liable for the denied services including any applicable deductible or coinsurance amounts and count the denial in the waiver calculation, and
- Prepare a denial letter to the beneficiary with a copy to the provider, include limitation of liability and appeals information. (See MIM §§3722.)

When needed, request additional information to substantiate the coverage of a service. Carriers shall request additional information before deciding to deny or reduce an unassigned claim that is not reasonable and necessary. Carriers may develop other claims as needed.

## **5.4 – HCFA Mandated Edits**

### **A – Mandated Edit for Carriers**

The HCFA mandated edit for carriers is:

- Inpatient Rehabilitation Medicine Visits.

Identify claims for an unusually large number of visits by psychiatrists to a patient in a rehabilitation facility (HCPCS codes 99221-99238). (Automated system edit number 0019.)

### **B – Mandated Edit for Intermediaries**

The HCFA mandated edits for intermediaries are:

- SNF Demand Claims.

## **6 - Postpayment Review of Claims**

### **{tc "5 -- Post-payment Review of Claims "} "**

Post-payment MR encompasses those activities required to address overutilization or abusive billing by making a benefit category, statutory exclusion, reasonable and necessary, or local coding decision after claim adjudication. These activities require the application of clinical expertise or the use of internal MR guidelines based on medical expertise.

Typically, post-payment review of claims is conducted for a specified provider or group of providers in order to evaluate the provider(s) billing patterns over a selected period of time. Contractors are not precluded from reviewing claims for other reasons on a postpayment basis. The MR unit may uncover fraud in the course of its post-payment review activities and as a result refers these cases to the fraud unit. The fraud unit may identify providers that should be referred to the MR unit for inclusion on their CMR list. Post-payment review, at a minimum, is appropriate for providers that have sought to defraud. When contractors determine a retrospective study of a provider or group of providers is warranted, they follow the instructions for CMR in the PIM Chapter 3, §6.1. Post-payment review of claims is a result of the following:

- **Selection for CMR of individual or a group of providers with the greatest likelihood of overutilization;**
- **Review of claims for purposes other than CMR, such as investigating a complaint or follow up to determine if an educational contact resulted in changed behavior;**
- **Decision to initiate suspension of payment for a given provider ( PIM Chapter 3, §§8);**

- **Identification of situations that require prepayment edits and/or LMRPs; and/or**
- **Referrals may be made to the FU with recommendations for administrative sanctions (including civil and criminal prosecution) under §1128(A) of the Act for providers who fail to correct their inappropriate practices. (See PIM Chapter 1, §4 and Chapter 3, §10.)**

If intermediaries perform MR of outpatient hospital claims on a postpayment basis, they must complete the review, notify the provider of denials, and initiate recovery of the overpayment if applicable, within:

- **Thirty days of the date the claim was processed if medical evidence was submitted with the bill or was not required; or**
- **Sixty days of the date the claim is processed if medical evidence had to be obtained from the provider.**

In cases, where on a post-payment basis, contractors identify past misapplication of Medicare policy, i.e., established in the law, regulation, Medicare manual, or the contractor local policy process, which resulted in Medicare payments for non-covered or unnecessary services, denials will occur and no future payments should be made. Medicare funds may only be disbursed in accordance with the terms of the Medicare policy. In these cases, contractors also consider recoupment of any overpayments. Initiation of overpayment recovery means, at the minimum, withholding or offsetting provider payments, or taking refund action against the provider.

## **6.1 - Comprehensive Post-payment MR {tc "5.1 -- Comprehensive Post-payment Medical Review " \1 2}**

CMR consists of thorough post-payment MR of a provider's claims and medical documentation. The CMR process allows contractors to determine whether a provider or group of providers suspected of providing non-covered or medically unnecessary services is, in fact, doing so.

CMR is done to determine whether the services meet the following criteria:

- **They are reasonable and necessary under Medicare law;**
- **They adhere to program requirements (e.g., physicians' orders and certifications; plans of treatment);**
- **They adhere to coverage requirements (e.g., beneficiary is confined to home for home health services, or services are not excluded); and**
- **Documentation is present to support that services were furnished.**

There are two types of CMRs.

The first CMR type is performed by intermediaries. It requires review of the provider's medical documentation at the provider's site but does not require valid statistical sampling methodologies, and does not allow projection of overpayments to the universe of claims

reviewed. In this type of CMR, contractors collect overpayments only on claims that are actually reviewed, determined to be non-covered, and the provider is liable or at fault for the overpayment. Contractors use the procedures for onsite CMR when the criteria for conducting CMRs using statistical sampling and overpayment projection methodologies are not met.

On-site CMRs may include:

- **Visits to selected beneficiaries' homes;**
- **Contact with individual physicians to verify documentation; and**
- **Team Reviews. (See Sub-section A below for definition of team reviews).**

The second CMR type requires valid statistical sampling and allows for projection of sample overpayments to the universe of claims. It also serves as the basis for overpayment assessment and projection. It is used by carriers and intermediaries.

Contractors use physicians, registered nurses, other professionally trained medical personnel, or experienced claims examiners to perform CMRs.

## **A – Team Reviews**

Intermediaries should conduct team reviews of providers wherever feasible. They use team reviews when potential problems exist in multiple areas. The team may consist of medical review, and/or audit and fraud and abuse staff, state surveyors, carrier and/or Medicaid staff depending upon the issues identified. At a minimum, prior to conducting CMRs consult and share information with other internal and external (as appropriate) staff to determine if there are issues that the reviewers should be aware of or if a team review is needed.

### **6.1.1 - Intermediary Selection of Providers for Comprehensive Medical Review (CMR) {tc "5.1.1 -- Intermediary Selection of Providers for Comprehensive Medical Review (CMR) " \1 3 }**

Intermediaries shall select providers for CMR based on results of data analysis, in-house MR and when CMRs are approved by the HCFA Regional Office (RO) or Central Office (CO). Reasons a provider may be selected for CMR include, but are not limited to, the following:

- **The intermediary has identified documented questionable billing practices, i.e., medically unnecessary or unreasonable services, overutilization of services, and other noncovered services through data analysis. This requires an in-depth review of medical records to determine the extent of the problems;**
- **The intermediary has documented a pattern of incorrect and/or potentially fraudulent or abusive billing practices in a substantial number of cases, e.g., no documentation to support that billed services were furnished, or billing for more services than were furnished;**
- **The intermediary has informed a provider of specific problem(s) in writing, and they continue to bill for the non covered services after sufficient time has elapsed for them to take corrective action ( a minimum of 60 days);**
- **The provider repeatedly fails to submit requested documentation, or they submit noticeably altered documentation;**
- **The provider has a pattern of not complying with physician certification, physician orders, or other similar requirements;**
- **The Office of the Inspector General recommends a CMR as a result of documented noncompliance with medicare requirements; or**
- **Alerts from other intermediaries, carriers, PROs, intermediary payment staff, or other internal components are received that warrant an in-depth review.**

Intermediaries must document their reasons for selecting the provider for the CMR. In all cases, they must clearly document the issues cited and the applicable law or their published medical review policy that supports the issue.

## **6.2 - Intermediary Procedures for Provider On-Site CMRs (Type 1) {tc "5.2 -- Intermediary Procedures for Provider On-Site CMRs (Type 1) " \1 2}**

### **A – Selection of Claims and Period to Review for On-Site CMRs**

Intermediaries select providers for CMR, and determine the claims and review period based on the following criteria:

- **Resources available to accomplish the review;**
- **Length of time the problem has existed; and**
- **The volume of claims at issue.**

Contractors select a minimum of 60 claims for review, and generally limit the review to claims processed within the most recent 4-6 month period. They do not select claims that are more than one year old.

They select the claims to review by:

- Picking a random sample of claims;
- Choosing claims with services identified as problem areas;
- Selecting beneficiaries; or
- Combining any of the above.

## **B – File Compilation for Onsite CMRs**

After the claims and review period are selected, intermediaries gather all pertinent in-house information needed with respect to the furnished services. They establish an audit trail that identifies the claims and beneficiaries selected and the period of review for medical records. They complete this prior to starting CMR.

When necessary, intermediaries use physician consultants and health professionals in various specialties to review or approve decisions involving medical judgement in their respective areas. Their review decision is made on the basis of local or HCFA policies in effect at the time of initial payment.

Intermediaries must document all findings to show why the original findings were changed. The documentation must be clear and concise, and include the basis for revision. (See PIM Chapter 3, §6.2 subsections E and G below.)

## **C - Performing On-Site CMRs**

Intermediaries must decide what, if any, advance notification of a scheduled CMR is to be given to a provider. They give advance notice when a provider has satellite offices from which medical records will have to be pulled. When giving advance notice, they use certified mail and advise the provider of the reason for review.

In conducting the CMR, intermediaries use staff who have the authority to deny claims. If denials occur, it is best that they happen during the on-site review unless the review requires input from the contractor physician or other medical consultant. In those cases, the contractor physician or other medical consultant is to make the final decision to deny the claim based on information gathered at the on-site interview.

Reviewers photocopy pertinent medical records only when services are denied, when a physician or other medical consultation is needed, or when it appears that records have been altered. When copying records, they do not intermingle them with other medical records.

Reviewers hold entrance and exit interviews with appropriate provider staff. A provider representative can also be present while CMR claims are reviewed.

During entrance interviews, reviewers explain the following:

- **Scope and purpose of the review;**
- **Why a CMR is being conducted;**
- **The list of claims that require medical records;**
- **Information on provider appeal and review rights (see PIM Chapter 3 §6.2D below and MIM §§ 3781-3781.4); and**
- **How monetary recoupment of any overpayment is made if claims are denied.**

Reviewers answer any questions the provider staff may have. During exit conferences, they discuss the findings of the CMR. The provider must be allowed an opportunity to discuss or comment on the claims decisions.

Where physician or other consultants are required, these reviews must be completed and included in the CMR notification letter. (See PIM Chapter 3 §6.2E below.)

## **D - Provider Rebuttal of Findings**

Within 15 working days of the exit conference or notification of the findings of the physician or other medical consultant, whichever is later, the provider may submit written comments or other documentation to show that a denial of services was not correct. This documentation could include letters from physicians, delayed certifications, re-certifications (see MIM §3323), documentation that was missing at the time of on-site review, or an explanation as to why the provider believes the decision to be in error. Intermediaries must consider all information received on-site or during the 15 days before making a final decision. They are not required to accept documentation that is completely unsupported by medical information or documentation that has clearly been altered.

## **E - Notification of CMR Results**

Contractors must prepare a letter (See PIM Chapter 3 §6.2H below for a sample letter.) to the provider informing them of the reason the CMR was conducted, CMR results, and the total overpayment amount within 60 calendar days of the exit conference. The letter must include:

- **A reason for conducting the review;**

- **An explanation of how the overpayment was determined;**
- **An explanation of why the provider may be held responsible for an overpayment;**
- **An explanation of what the provider can do as a result of the overpayment (i.e., how the overpayment will be recovered);**
- **An explanation of the provider's appeal rights (see MIM §§3781-3781.4);**
- **A discussion of problems identified and corrective actions taken;**
- **A specific explanation of why any services were determined to be non-covered, overpayment amounts, and provider and beneficiary liability determinations on each case reviewed.**

See MIM §§3708-3711, PIM Chapter 3, §6.3.3.4 and §§7 and 8 for determinations of liability, beneficiary notification, and recovery of overpayments.

The letter in subsection H below meets all requirements for provider notification. Use the language in subsection H (omit headings) making necessary changes to adapt to the particular situation.

## **F - Corrective Actions**

Contractors must take the following actions based on CMR results:

- **Recover overpayments for which the provider is liable and/or at fault (see MIM §3710);**
- **Pay or make adjustments for any under-payments;**
- **Educate the provider, either during the on-site visit or in follow-up contacts, to prevent further inappropriate billing and/or utilization of services that have proven to be medically unnecessary;**
- **Refer quality issues to the PRO;**
- **Coordinate with the PRO and carrier on interrelated billing problems;**
- **Initiate prepayment review;**
- **Make referrals to the RO and OIG for fraud and abuse investigation. If it is believed that the overpayment has been caused by fraud, do not request a refund until the fraud issue is resolved;**
- **Refer provider certification issues to the State survey agency through the RO staff.**

## **G - Documentation for CMR Cases**

Contractors must complete a CMR Summary Report for each CMR case. Include in the report:

- **The reason(s) the provider was selected for review;**
- **A chronological record of all review events and actions;**
- **The information used to perform the review;**
- **A record of all decisions made and all actions taken to deal with the provider's MR problem, including who made the decisions and the reasons for taking the actions; and**
- **A record of all contacts with providers or beneficiaries.**

Retain the CMR Summary Report for 36 months.

## **H - Sample Letter for On-Site CMRs**

See exhibit 7.

## **I - Attachment to Letter for On-site CMRs**

See exhibit 7.1

## **6.3 – Intermediary CMR Procedures Using Statistical Sampling for Overpayment Estimation (Type 2) {tc "5.3 – Intermediary CMR Procedures Using Statistical Sampling for Overpayment Estimation (Type 2) " \l 2}**

See exhibit 7.2

### **A – Use of CMR Sampling Procedures**

See exhibit 7.2.A.

### **B - Conducting A CMR.**

See exhibit 7.2.B.

### **C - When Sampling Is Appropriate**

See exhibit 7.2.C.

### **D – Consultation With a Statistical Expert**

See exhibit 7.2.D.

### **6.3.1 – Select Period To Be Reviewed and Composition of Universe {tc "5.3.1 – Select Period To Be Reviewed and Composition of Universe " \l 3}**

## **A – Selection of Period for Review**

See exhibit 7.3.A

## **B – Composition of Universe**

See exhibit 7.3.B

## **C – Adherence to Reopening Rules**

Intermediaries must adhere in all cases to reopening rules. An initial, revised, or reconsidered determination of HCFA made on a Part A claim, which is otherwise binding, may be reopened by the intermediary within 12 months from the date of the notice of the initial or reconsidered determination, or within four years after the date of the notice of the initial determination upon establishment of good cause for reopening such determination. (See 42 CFR 405.750; 20 CFR 404.988(b) and 404.989; MIM §§3799.) An initial, revised, or reconsidered determination made on a Part A claim may also be reopened at any time when the determination was procured by fraud or similar fault.

An initial or review determination made on a Part B claim may be reopened by the intermediary within 12 months from the date of the notice of the initial or review determination or within four years from the date of the notice of the initial determination upon establishment of good cause for reopening such determination. An initial or review determination may be reopened upon request of a party to the determination or by an authorized representative in limited circumstances. (See MIM §§3799.) An initial or review determination made on a Part B claim may also be reopened at any time when the determination was procured by fraud or similar fault. (See 42 CFR 405.841; MIM §§3799.)

A decision by a Hearing Officer (HO) may be reopened only by the HO (with very limited exceptions, see MIM §§3799.6, 3799.11, 3799.13 ) within 12 months from the date of the decision, or within four years from the date of the initial determination upon establishment of good cause for reopening such decision. (See 42 CFR 405.841.) A decision of the HO may be reopened at any time if it was procured by fraud or similar fault. (See 42 CFR 405.841; MIM §3799.10.)

**Note:** Decisions of an Administrative Law Judge (ALJ) or the Medicare Appeals Council within the Departmental Appeals Board (Appeals Council) may be reopened only by the ALJ or the Appeals Council under the procedures outlined in 20 CFR 404 Subpart J.

### **6.3.2 – Select Sample {tc "5.3.2 – Select Sample " \l 3}**

See exhibit 7.4.

#### **6.3.2.1 – Select Sample Design {tc "5.3.2.1 – Select Sample Design " \l 4}**

See exhibit 7.4.1.

## **A – Random Number Selection**

See exhibit 7.4.1.A.

### **6.3.2.2 – Select Sample Size and Claims to Include {tc "5.3.2.2 – Select Sample Size and Claims to Include " \l 4}**

See exhibit 7.4.2.

## **A – Claims to Be Included in the Sample**

See exhibit 7.4.2.A.

## **B – Relationship of Sampling Units to Provider Cost Reports**

See exhibit 7.4.2.B.

### **6.3.2.3 – Document Universe and Frame {tc "5.3.2.3 – Document Universe and Frame " \l 4}**

See exhibit 7.4.3.

## **A – Arrangement and Control Totals**

See exhibit 7.4.3.A.

## **B – Controls and Worksheets**

See exhibit 7.4.3.B.

### **6.3.3 – Actions After Provider and Sample Have Been Selected {tc "5.3.3 – Actions After Provider and Sample Have Been Selected " \l 3}**

See exhibit 7.4.4.

#### **6.3.3.1 – File Compilation and Provider Notification of the CMR {tc "5.3.3.1 – File Compilation and Provider Notification of the CMR " \l 4}**

See exhibit 7.4.4.1.

## **A – Exhibit-Sample Letter--Request For Medical Records**

See exhibit 7.5.

#### **6.3.3.2 – Onsite and In-House Reviews {tc "5.3.3.2 – Onsite and In-House Reviews " \l 4}**

Onsite reviews are performed at the provider's location. In-house reviews are performed at the contractor's location.

MR considerations in determining whether to conduct a review onsite are:

- **the extent of aberrant patterns identified in their focused review program;**
- **the presence of possible program integrity issues; and**
- **the past failure of a provider to submit appropriate and timely medical records.**

## **A – In-House Reviews**

MR notifies providers by certified letter and return receipt requested (retain all receipts) of the following:

- **why the CMR is being conducted;**
- **the list of claims that require medical records;**
- **information on the provider's appeal rights;**
- **possible methods of monetary recovery if claims are denied; and**
- **how results will be projected to the claims universe.**

They allow providers 30 days from the date of the certified letter to provide the medical record information. (See PIM Chapter 3, §6.3.3.1A above for a sample letter.)

If the information requested is not received within 30 days, MR reviews the claims with the information on hand. If this is not possible, they may want to conduct a CMR onsite. The 30-day time limit for medical records may be extended at their discretion. They complete the CMR and notify the provider in writing of their findings within 60 days from the start of the CMR, or receipt of medical records, whichever is later. (PIM Chapter 3, §6.3.3.6 and §6.3.3.6A and §6.3.3.6C.)

## **B – Onsite Reviews**

MR determines what, if any, advance notification of a scheduled CMR is given to a provider. They may give advance notice when a provider has satellite offices from which medical records will have to be retrieved. When giving advance notice, they use certified mail and return receipt requested.

MR includes the following information in an advance notice:

- **an explanation of why the CMR is being conducted;**
- **information on the provider's appeal rights;**

- **possible methods of monetary recovery if claims are denied;**
- **an explanation of how results will be projected to the claims universe.**

The list of claims requiring medical records may be included with the advance notice or at the time of the visit at the discretion of MR. They notify the provider accordingly.

## **C – Staff**

If denials occur, they occur during the onsite review by staff trained in claims review unless a review by physician or other medical consultant is required. When the final decision to deny the claim is made by a physician or other health care consultant, that decision is based upon information gathered at the onsite review as well as the information in MR files.

## **D – Copying Records**

Reviewers do not routinely photocopy medical records. They only photocopy pertinent medical records when services are denied, where physician or other health care consultation is needed, or where records may have been altered.

## **E – Entrance and Exit Interviews**

Reviewers hold entrance and exit interviews with the appropriate provider staff. During entrance interviews, they explain the following:

- **the scope and purpose of the review;**
- **why the CMR is being conducted;**
- **the list of claims which require medical records;**
- **information on the provider’s appeal rights;**
- **how monetary recovery can be made if claims are denied;**
- **how results will be projected to the claims universe; and**
- **they attempt to answer staff questions related to the review.**

During exit conferences they discuss the basic findings of the review and allow the provider an opportunity to discuss or comment on the claims decisions made onsite.

MR must send a letter detailing the results of the CMR, including all physician or other health care consultations required, within 60 days after the exit conference. They must complete reviews and include the results in the letter. Refer to PIM Chapter 3 §§6.3.3.6 and 6.3.3.6A and 6.3.3.6C for content of final notification letter.

### **6.3.3.3 – Re-adjudication and Documentation of Claims** {tc "5.3.3.3 – Re-adjudication and Documentation of Claims " \1 4

}

MR must re-adjudicate the claims in the sample making determinations in accordance with §§1879 and 1870 of the Social Security Act (the Act). (See also PIM Chapter 3, §6.3.3.4.)

Reviewers obtain whatever additional evidence is necessary for an objective and thorough evaluation of the payments that have been made. They use physician consultants and health professionals in the various specialties as necessary to review or approve decisions involving medical judgment in their respective areas. They make decisions based on Medicare law, rules and regulations, and HCFA policies or local intermediary medical review policies that were in effect at the time of initial payment or denial.

Reviewers document all findings made upon re-adjudication so that it is apparent from the written documentation why their original finding was changed. They document all items/services incorrectly denied. They report services newly denied as a result of re-adjudication as positive values and they report services that were denied but are reinstated as a result of re-adjudication as negative values.

They document the amount of the over/underpayment and how it was determined in conjunction with Audit/Reimbursement staff. (See PIM Chapter 3, §6.3D.)

**Note:** Do not adjust the "individual claims" since the overpayment will be handled as a lump sum adjustment. Adjustment without projection will be done only if the estimated precision of the value results in a zero correction based on the estimate.

MR must assure documentation is clear and concise and includes the basis for revisions in each case (this is important for provider appeals). They include copies of the local medical review policy and any applicable references needed to support individual case determinations. Compliance with these requirements facilitates adherence to the provider notification requirements in PIM Chapter 3, §6.3.3.6.

#### **6.3.3.4 – Effect of Sections 1879 and 1870 of the Social Security Act {tc "5.3.3.4 – Effect of Sections 1879 and 1870 of the Social Security Act. " \1 4}**

The Medicare law contains two provisions which affect the determination and the recovery of overpayments. One is §1879 of the Act, which deals with limitation on liability for services determined to be noncovered because they are, for example, custodial or are not reasonable and necessary under Medicare law, or, for home health services, the patient is not confined to home or the skilled nursing services are not intermittent.

The other law affecting the determination and the recovery of overpayments is §1870 of the Act, which provides a framework within which liability for overpayments is determined and recovery of overpayments is pursued.

To arrive at the §1870 determination, intermediaries must determine if the provider is without fault for the overpayment. A provider is considered without fault if: (1) it exercised due care in billing and accepting payment, i.e., it made full disclosure of all material facts; and (2) on the basis of the information available to it, including but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct.

## **A – Section 1879 of the Act Determinations and Recoveries**

If the denial involves services to which the provisions of §1879 (limitation on liability) apply, MR makes a determination in accordance with instructions in MIM §§3439 - 3441 and HCFA Ruling 95-1. If, under §1879 of the Act, both the provider and beneficiary are found not to have known or not to have had reason to know services were not covered, payment by the Medicare program is required under the limitation on liability provision and therefore, there is no overpayment.

If either the beneficiary or the provider is found to be liable under §1879 of the Act, an overpayment exists. Whether the amount of an overpayment should be included in the sample overpayment used as the basis of the projection depends upon the determination under §1870 of the Act. Only amounts of overpayments for which the provider is not without fault should be included in the sample overpayment.

## **B – Section 1870 of the Act Determinations and Recoveries**

If the denial of a claim involves services to which the provisions of §1879 (limitation on liability) do not apply, or if an overpayment results from a §1879 determination that either the beneficiary or the provider is liable, intermediaries make a determination as to whether the provider was without fault for the overpayment under the provisions of §1870 in accordance with MIM §§3708 - 3708.2.

**Note:** If the provider is found to be liable under §1879, that determination is ordinarily sufficient to support a finding that the provider is not without fault under §1870. However, intermediaries must document both their §1870 and §1879 determinations, and notify the provider accordingly.

If the provider is determined to be not without fault for the overpayment, the amount of the overpayment should be included in the sample overpayment to be projected. If the provider is found to be without fault under §1870, the provider is not liable for the amount of the overpayment. Therefore, intermediaries must not include the amount in the sample overpayment (i.e., the amount is included as a zero value for the provider's sample overpayment). (Refer to MIM §3711 for recovery of the overpayment from the beneficiary.)

### **6.3.3.5 – Estimate of the Correct Payment Amount and Subsequent Over/Underpayment {tc "5.3.3.5 – Estimate of the Correct Payment Amount and Subsequent Over/Underpayment " \1 4}**

The results of the re-adjudication of the sampling units are used to project an estimate of the total overpayment amount. MR must refer to instructions in PIM Chapter 3, §§6.3.7, 6.3.8, 6.3.9 and 6.3.10 for projection methodologies based on provider types.

Amounts of the following overpayments are to be included in the estimate of overpayments for the sample:

- **Initially paid claims which are denied on re-adjudication, and for which the provisions of §1879 apply and the provider is liable for the overpayment because:**  
**(1) the provider knew or could reasonably have been expected to know that items**

or services were excluded from coverage, and (2) the provider was not without fault for the overpayment under §1870.

- **Initially paid claims which are denied on re-adjudication, and for which the provisions of §1879 do not apply, but the provider is liable because it is determined to be not without fault for the overpayment under §1870.**
- **Initially denied claims which are found to be payable on readjudication (in whole or in part). Such claims should be included to reduce the amount of the overpayment sample.**

For appeal purposes, overpayment estimations will be separately identified for denials in which §1879 is applied, and denials in which §1879 does not apply. (See MIM §§3780 for specific provider appeal rights.) Where both types of denials occur in the sample, intermediaries calculate and document separate under/overpayments for the two types of denials. For recovery purposes, however, both denial results are combined.

### **6.3.3.6 – Final Notification of the CMR Results/Demand Letter {tc "5.3.3.6 – Final Notification of the CMR Results/Demand Letter " \1 4}**

Medical reviewers must prepare a letter to notify the provider of the results of the CMR, and to request repayment of any overpayments they may have made. This letter must contain:

- **Identification of the provider(s)--name, address, and provider number;**
- **An explanation of why the review was conducted;**
- **A narrative description of the overpayment situation: state the specific issues involved which created the overpayment and any pertinent issues;**
- **Total underpayment amounts;**
- **Total overpayment amounts for which the provider is responsible;**
- **Total overpayment amounts for which the provider is not responsible because the provider was found to be without fault;**
- **An explanation of the sampling methodology, i.e., a description of the universe, the frame, and sample design, a definition of the sampling units, decisions concerning the sample selection procedure, the numbers and definitions of the strata and size of the sample, including allocations if stratified, the time period under review, the sample results including both the estimate of overpayment and the calculated sampling error as estimated from the sample results, any non-sampling error factors that might affect the validity of the results, the actual overpayment or underpayment amounts, and the amount of the extrapolated overpayment;**

- **An explanation that the overpayment amount is an estimate and that subsequent adjustments may be made at cost settlement to reflect final settled costs;**
- **A list of all individual claims including the actual amounts determined to be noncovered, the specific reason for noncoverage, the amounts denied, the amounts which will not be recovered from the provider, under/overpayment amounts and the §§1879 and 1870 determinations made for each specific claim;**
- **A list of any problems/issues identified as well as any recommended corrective actions;**
- **An explanation of the provider's right to submit a rebuttal statement prior to recoupment of any overpayment;**
- **An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider's right to request an extended repayment schedule;**
- **A list of all provider appeal rights; and**
- **Any other information required by regulation or manual for the specific services MR is denying.**

MR provides a copy of the final notification letter containing the results of their review to the provider within 60 days of either the exit conference, if the review was conducted on-site, or the completion of the in-house review. The final notification letter must be sent by **certified mail and return receipt requested**. A copy of the final notification letter must be sent to the RO and they will send a copy of the demand letter to CO.

Sample letters are in PIM Chapter 3, §§6.3.3.6A and 6.3.3.6C. MR may adapt the language used under each heading to the particular situation they are addressing.

MR must send individualized claim determinations to the provider for each claim included in the sample. They must also send notice to the beneficiary when re-adjudication of the claim results in a change to the initial determination. Beneficiary notification requirements are found in MIM §3710.3.

### **A – Exhibit: Part A Sample Letter Notifying the Provider of the CMR Results, and Request Repayment of Overpayments**

See exhibit 7.6

### **B – Exhibit: Attachment to the Part A Letter Notifying the Provider of the CMR Results, and Request Repayment of Overpayments**

See exhibit 7.6.1.

## **C – Exhibit: Part B Sample Letter Notifying the Provider of the CMR Results, and Request Repayment of Overpayments**

See exhibit 7.7.

## **D – Exhibit: Attachment to the Part B Letter Notifying the Provider of the CMR Results, and Request Repayment of Overpayments**

See exhibit 7.7.1.

### **6.3.4 – Recovery of Overpayment and Corrective Actions {tc "5.3.4 – Recovery of Overpayment and Corrective Actions " \1 3}**

After MR issues revised determinations that notify the provider of the CMR results, their intention to recoup or offset payment and the provider's right to submit a rebuttal statement (see PIM Chapter 3, §§6.3.3.6 and 6.3.3.6A and 6.3.3.6C), the Audit/Reimbursement (A/R) staff may begin recovery of the lower bound of the estimated total overpayment on the 15th day from the date of the notification letter to the provider. (See also MIM §§2220 - 2229, and MIM §§3707 - 3711.)

Prior to recoupment of overpayments, providers and suppliers have a right to submit a rebuttal statement in accordance with 42 CFR 405.370-375. The rebuttal statement and any accompanying evidence must be submitted within 15 days from the date of the CMR notification letter described in PIM Chapter 3, §6.3.3.6 unless MR or Audit/reimbursement staff find cause otherwise to extend or shorten the time afforded for submission of the statement. The provider's rebuttal statement should address why the recovery should not be put into effect on the date specified in the notification letter. MR and AR staff should consider all of the evidence timely submitted to reach a determination regarding whether the recoupment should be delayed. However, recovery of any overpayment will not be delayed beyond the date indicated in the CMR notification letter in order to review and respond to the rebuttal statement. (See 42 CFR 405.375(a).)

Substantive evidence that MR claims determinations were incorrect generally should not be considered during the rebuttal process unless such evidence relates to the timing of the recoupment of the overpayment. Substantive evidence on claims determinations is properly heard during a reconsideration under Part A or a review determination or HO hearing under Part B. However, in order to avoid unnecessary appeals, if it is clear from the evidence submitted that MR revised determination was in whole, or in part, incorrect, they may consider such evidence. If such evidence warrants changes to any claims determinations made during the reopening, they work with Audit/Reimbursement staff to recalculate the amount of the overpayment, and issue a modified revised determination in accordance with the procedures in PIM Chapter 3, §6.3.3.6.

Should MR issue a modified revised determination, they send notice of the results of the modification to any beneficiary whose claims have been affected. In addition, they notify the provider that the applicable time period for filing a request for reconsideration of Part A services or a review determination of Part B services begins on the date of the modified revised determination. **However, recovery of any overpayment, even if the principal of the debt is**

**modified after reviewing the rebuttal statement, will not be delayed beyond the date indicated on the revised determination.** Furthermore, since the provider has previously had an opportunity to submit a rebuttal statement, MR is not required to offer a provider an opportunity to submit a rebuttal statement in response to the modified revised determination. The provider may challenge the claims determinations and sampling methodology in the administrative appeals process.

Because of the cost report relationship to the overpayment, it is important to note that the projected overpayment recovered from a provider as a result of a CMR using statistical sampling is based on the interim payment rate in effect at the time of the CMR. A/R may make subsequent adjustments when the cost report is settled to reflect final settled costs.

## **A – Corrective Actions**

In addition to MR referring results of the CMR to the Audit/Reimbursement Unit, they take any other corrective actions they deem necessary. (See PIM Chapter 3, §§6 and 6.1.) If, as a result of the CMR, they suspect fraud, they refer results of the CMR to their Fraud Unit for referral to the appropriate law enforcement agency.

### **6.3.5 – Administrative and Judicial Appeal Rights {tc "5.3.5 – Administrative and Judicial Appeal Rights " \l 3}**

A CMR requires that providers and beneficiaries be informed of their appeal rights in all overpayment final notification letters and determinations. The following outlines the appeals provisions in the order that they are carried out:

Under the Medicare statute, beneficiaries and providers may appeal MR determinations in limited circumstances, and may only appeal specific aspects of their determinations. (See §1862(a)(1) and (9), §1879 of the Act (as amended by §4447 of the BBA); HCFA Ruling 95-1; 42 CFR 405 Subparts G and H and 411.400; and MIM §3793.)

## **A – Part A Services – Reconsideration**

Since MR is conducting a postpayment review of claims, the CMR conducted on the sample of claims is considered a reopening. (See 42 CFR 405.750; MIM §3799.) MR notifies the parties of any changes to the initial determination made on the claims in the sample and issues a revised determination. (See 42 CFR 405.702 and 405.750; and MIM §3799.14;.) The first level of administrative appeal of a revised determination is a reconsideration pursuant to 42 CFR 405.710. (See also, MIM §3799.14.)

For denials to which the limitation on liability provisions of §1879 apply, a provider may assert the same appeal rights as the beneficiary when the beneficiary does not exercise his right to appeal or is not liable. (See §1879(d) of the Act; 42 CFR 405.710(c); HCFA Ruling 95-1; MIM §§3781.2 - 3781.3.)

To determine which, if any, issues the provider may appeal, consult §1879 of the Act; HCFA Ruling 95-1; 42 CFR 405.704(c) and 405.710; and MIM §§3781. The provider may also challenge the validity of the sample selection, the validity of the statistical projection of the

sample results to the universe, and the determination that the provider was not without fault under §1870 of the Act.

The request for reconsideration must be filed within 60 days after the date of receipt of the notice of initial determination. The date of receipt is generally presumed to be five (5) days after the date of the notice. (See 42 CFR 405.711.)

## **B – Part A Services – Administrative Law Judge (ALJ), Appeals Council, Judicial Review**

If the reconsidered determination affirms the revised determination in full or part, the next level of administrative appeal is an ALJ hearing, provided the amount remaining in controversy is \$100 or more. (See 42 CFR 405.720 and 405.745.) The amount in controversy is based on the extrapolated amount.

A request for hearing must be filed within 60 days after the date of receipt of the notice of the reconsidered determination. The date of receipt is generally presumed to be five (5) days after the date of the notice. (See 42 CFR 405.722.) Any issue appealable on reconsideration may be appealed.

## **C – Part A Services – Medicare Appeals Council**

Following an ALJ hearing, a provider may appeal to the Medicare Appeals Council within the Departmental Appeals Board (hereinafter, Appeals Council). (See 42 CFR 405.724 and 20 CFR 404.967ff.) A request for Appeals Council review must be filed within 60 days after the receipt of the notice of the ALJ hearing decision or dismissal. The date of receipt is generally presumed to be five (5) days after the date of the notice. (See 20 CFR 404.901.)

To the extent authorized by §§1869 and 1879(d) of the Act, a party to an Appeals Council decision or an ALJ decision if the Appeals Council does not review the ALJ decision, may obtain court review if the amount remaining in controversy is \$1,000 or more, and a complaint is timely filed in accordance with the provisions of §205(g) of the Act and the procedures outlined in 20 CFR 422.210. (See 42 CFR 405.730.)

## **D – Part B Services – Revised Determination**

Since MR is conducting a postpayment review of claims, the CMR conducted on the sample of claims is considered a reopening. (See 42 CFR 405.841; PIM Chapter 3, §6.3.2.) They should notify the parties of any changes to the initial determination made on the claims in the sample and issue a revised determination. (See 42 CFR 405.842; MIM §§3799; PIM Chapter 3, §§6.3.3.6, and 6.3.3.6C.)

## **E – Part B Services – HO Hearing**

The first level of administrative appeal following a revised determination is a hearing before a HO, provided the request for review is filed timely, and the amount remaining in controversy is \$100 or more. (See 42 CFR 405.815 and 405.842; MIM §§3794.) The amount in controversy is based on the extrapolated amount. The time limit for filing a request for hearing is six (6) months from the date of the notice of the review determination.

For denials to which the limitation on liability provision applies (§1879 of the Act), a provider may assert the same appeal rights as the beneficiary when the beneficiary does not exercise his right to appeal or is not liable. (See §1879(d) of the Act; 42 CFR 405.801ff; HCFA Ruling 95-1.)

To determine which, if any, issues the provider may appeal, consult §1879 of the Act; HCFA Ruling 95-1; 42 CFR 405.801, 405.815, and 405.842; MIM §§3791. The provider may also challenge the validity of the sample selection, the validity of the statistical projection of the sample results to the universe, and the determination that the provider was not without fault under §1870 of the Act.

## **F – Part B Services – ALJ Appeals Council and Judicial Review**

If the amount remaining in controversy is \$500 or more, the next level of administrative appeal is a hearing before an ALJ. A request for hearing must be filed within 60 days after the receipt of the notice of the Hearing Officer's decision. The date of receipt is generally presumed to be five (5) days after the date of the notice. The provider may appeal any issue that was appealable to the HO. (See 42 CFR 405.801, 405.855.)

## **G – Part B Services – Appeals Council**

If the ALJ decision is unfavorable to the provider in full or in part, the provider may request Appeals Council review. (See 42 CFR 405.856; 20 CFR 404.967ff.) A request for Appeals Council review must be filed within 60 days after the receipt of the notice of the ALJ hearing decision or dismissal. The date of receipt is generally presumed to be five (5) days after the date of the notice. (See 20 CFR 404.901.) To the extent authorized by §§1869 and 1879(d) of the Act, a party to an Appeals Council decision or an ALJ decision if the Appeals Council does not review the ALJ decision, may obtain court review if the amount remaining in controversy is \$1,000 or more, and a complaint is filed timely in accordance with the provisions of §205(g) of the Act and the procedures outlined in 20 CFR 422.210. (See 42 CFR 405.801, 405.815, 405.857.)

### **6.3.5.1 – Effect of Pending Appeals on Recovery of Overpayments {tc "5.3.5.1 – Effect of Pending Appeals on Recovery of Overpayments " \l 4}**

Intermediaries may recover any overpayments in accordance with 42 CFR Part 401, Subpart F and 42 CFR 405.373ff. They do not institute any overpayment recovery until the provider has been notified of the existence of the overpayment and the reasons for their decision to recoup the overpayment, and until the provider has had an opportunity to submit a rebuttal statement in accordance with 42 CFR 405.374. (See PIM Chapter 3, §§6.3.3.6, 6.3.4, 6.3.3.6A and 6.3.3.6C.) Refer to PIM Chapter 3, §6.3.4 for applicable procedures.

### **6.3.5.2 – Changes Resulting from Provider Appeals {tc "5.3.5.2 – Changes Resulting from Provider Appeals " \l 4}**

If the decision issued on appeal contains a finding that the sampling methodology was flawed, there are several options for changing the sampling results:

- **First, if the decision issued on appeal permits correction of errors in the sampling methodology, the intermediary should revise the overpayment determination after making the corrections. They consult with CO through the RO to determine whether such an action is consistent with the ALJ or Appeals Council decision or court order;**
- **Second, the intermediary may elect to recover the actual overpayment related to the sample claims that were paid in error and they may initiate a new CMR for the provider. The claims sampled for the new CMR must be drawn from a time period different from the one from which claims in the previous CMR were drawn. The intermediary should consult with CO through the RO to determine whether such an action is consistent with the ALJ or Appeals Council decision or court order;**
- **Third, the intermediary may conduct a new CMR (using a new methodology) for the same time period as was covered by the previous CMR. Before employing this option, they should consult with CO through the RO to verify that the action is consistent with the ALJ or Appeals Council decision or court order. If the third option is chosen, they also may not recover the overpayments on any of the sample claims found to be in error in the original sample.**

If the decision on appeal upholds the sampling methodology but reverses one or more individual claims determinations, MR must recompute the estimate of overpayment. (See PIM Chapter 3, §§6.3.3.5.)

If the decision on appeal reverses one or more individual claims determinations and the sampling methodology, MR takes one of the actions specified above, excluding from the sample all individual claims for which a reversal was given.

### **6.3.6 – Cost Report Appeal Issues {tc "5.3.6 – Cost Report Appeal Issues " \1 3}**

#### **A – Appeal of Cost Report Adjustment**

When the CMR results in an overpayment or underpayment adjustment to the final cost report as reflected on the written “Notice of Program Reimbursement (NPR),” and the provider or other entity is dissatisfied with this cost report adjustment, the provider or other entity may request an intermediary or Provider Reimbursement Review Board (PRRB) hearing for a very limited purpose only.

The provider may dispute to the PRRB the method of determining provider costs in the cost reporting process that are reflected on the NPR. As a general matter, the individual claims determination, sampling methodology, and amount of over/under payment extrapolation related to the CMR should not be appealed to the PRRB (refer to the administrative and judicial review processes described in PIM Chapter 3, §6.3.5 for appeal of these issues).

As a general matter, the request for hearing of the method must be filed within 180 days from the date of receipt of the NPR.

If the amount in controversy is at least \$1,000 but less than \$10,000, a request for hearing must be filed with the intermediary. The amount in controversy is determined by subtracting the provider's calculation of the adjustment to the cost report as a result of the CMR from the intermediary's calculation of that adjustment.

If the amount in controversy is at least \$10,000, a request for hearing must be filed with the PRRB. The amount in controversy is determined by subtracting the provider's calculation of the adjustment to the cost report as a result of the CMR from the intermediary's calculation of that adjustment.

## **B – Changes Resulting from Provider Appeals**

If the decision issued on appeal contains a finding that the method by which the extrapolated under/overpayment resulting from the CMR was converted to provider costs in the cost reporting process was flawed, intermediaries must correct the errors in the methodology, they re-compute the amount based on the finding, and issue a revised NPR.

### **6.3.7 – Projection Methodologies and Instructions for Reviews of Home Health Agencies {tc "5.3.7 – Projection Methodologies and Instructions for Reviews of Home Health Agencies " \l 3}**

See exhibit 9.

### **6.3.8 – Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs) {tc "5.3.8 – Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs) " \l 3}**

See exhibit 10.

### **6.3.9 – Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS) {tc "5.3.9 – Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS) " \l 3}**

See exhibit 11.

### **6.3.10 – Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs) {tc "5.3.10 – Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs) " \l 3}**

See exhibit 12.

## **6.4 – Carrier CMR Procedures {tc "5.4 – Carrier CMR Procedures " \l 2}**

### **6.4.1 - CMR Case Selection**

{tc "5.4.1 -- CMR Case Selection " \l 3

CMRs are usually targeted to providers, whether individuals or groups, who have demonstrated aberrant billing and/or practice patterns. Carriers must use all available relevant information when selecting CMR cases.

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Case selection is based on profiling providers who have generated one or more assigned or unassigned claims during the period under review. Carriers use UPINs for physicians and individual PINs for non-physicians. DMERCs should use the NSC issued supplier numbers. As with physician UPINs and PINs, it may be appropriate to analyze suppliers by their six-digit base number and their 10-digit (six-digit base plus four-digit) location ID number. It may be necessary to conduct sub-studies of locality practices for physicians using their PINs because physicians with one UPIN may have different practices with multiple PINs. Their patterns of practice may vary across different locations (e.g., hospital based, office based, SNF based), especially when physicians designate different specialties for their different PINs. Carriers must use all available relevant information when selecting CMR cases. Potential sources for referrals or review possibilities include aberrancies identified through the data analyses of paid claims, including standard post-payment claims data reports, and alerts received from other carriers, intermediaries, PRO, and State Medicaid agency. In addition, providers may be identified by the following:

- **Fraud alerts;**
- **MR staff;**
- **Fraud unit;**
- **Review staff or hearing officers;**
- **OIG;**
- **HCFA;**
- **Audit;**
- **Other contractor units;**
- **Private business staff;**
- **Newspaper accounts of provider's billing practices;**
- **Questionable newspaper or television advertising; and**
- **Other sources.**

**Note:** In the process of selecting providers for CMRs, MR staff should review the Provider Tracking System and consult with the Fraud unit to ensure duplicate efforts are not being undertaken. (See PIM Chapter 2 §2.11 subsection D.)

Carriers focus CMRs on providers who have demonstrated aberrant billing and/or practice patterns. They use all available information relevant to the provider community when selecting CMR cases.

## **6.4.2 -- Conducting the CMR {tc "5.4.2 -- Conducting the CMR " \1 3}**

CMR is a thorough analysis of a sample of processed claims and all pertinent data (such as medical records, beneficiary payment history, etc.), for selected providers, for a specified time period. Carriers may also conduct CMRs using other methodologies (e.g., service based sampling) with approval from the RO. For each provider selected, they conduct CMR using the steps listed below.

### **A - Identify Beneficiary Sample for the Service(s) Under Review**

The first step in conducting a CMR is the identification of all beneficiaries who received the service under review from the provider or group of providers for the specified time period (this is termed the "universe") followed by selection of a sample of these beneficiaries. Carriers work with their statistical staff to identify a proper sample. There are three sampling options that may be used.

They are as follows:

- **Randomly select a minimum of 15 beneficiaries from the universe of beneficiaries who received the service under review from the provider(s). This option is known as a "limited sample." Contractors cannot project overpayment if this approach is used, though a consent settlement can be offered.**
- **Select a statistically valid random sample (SVRS) of beneficiaries from the universe of beneficiaries who received the service under review from the provider(s). (Contractors may use the MCM Sampling Guidelines Appendix or methods developed by contractor statisticians. Since contractors may be required to defend the methodology on appeal, carefully document methods used.); or**
- **Select a SVRS of beneficiaries from the universe of beneficiaries who received the service under review from the provider(s), and then randomly select a minimum of 15 beneficiaries from the SVRS. This option is known as a "limited SVRS sub-sample".**

Use acceptable sampling techniques and maintain documentation describing the technique as part of the record. Consider including the description of sampling techniques with notices that inform the provider or group of providers that a CMR is being conducted.

### **B - Obtain Beneficiary Medical Records Associated With the Claims**

Carriers must notify the provider or group of providers that a CMR is being conducted and request medical records pertinent to services being investigated for each beneficiary in the sample for a period of at least 6 months. They ensure that all records requested are from the period under review.

### **C - Review All Claims and Requested Medical Records**

Carriers review paid claims and medical records for the services within the time period. They use national coverage guidelines and LMRP in effect at the time of payment to determine whether the services were covered, appropriately coded, and whether the documentation supports the level of service billed.

## **D - Notice of CMR Completion**

Contractors must notify the provider or group of providers upon completion of the CMR even in those instances where no corrective actions or overpayments are involved. A CMR is completed at the time the contractor has assessed any overpayments that can be communicated to the provider. If no overpayment is assessed, then a CMR is completed at the time corrective action is taken.

## **E - Taking Corrective Action**

If the review of the claims and corresponding records substantiates the service billed, carriers close the case and notify the provider or group of providers. If the review shows a need for corrective actions, they must proceed with the CMR process. Corrective actions must be initiated within 12 months of the date the provider or group of providers was selected for CMR.

### **6.4.3 - CMR Corrective Actions {tc "5.4.3 -- CMR Corrective Actions " \1 3}**

Corrective actions for providers as a result of CMR, regardless of identification method (see PIM Chapter 3), include:

- **Educate the provider (individuals or groups). Anytime individual providers are contacted because of overutilization, provide comparative data on how they vary significantly from other physicians in the same payment area or locality. The comparative data should include graphic presentations;**
- **Send a warning letter to alert the provider or group of providers that they are being monitored for unusual billing practices;**
- **Develop a provider specific edit to focus prepayment review on the problem provider or group of providers;**
- **Calculate overpayments and refer to overpayment staff for recoupment ;**
- **Work with the RO to suspend payment to the provider or group of providers; and/or**
- **Refer cases of potential fraud to the fraud unit. If there is a pattern of abuse, or if the contractor has issued warnings in the past to the provider or group of providers for this or comparable practices, discuss the case with the fraud unit before taking any action. To be considered corrective action, the fraud unit must agree that there is the strong potential for fraud or a pattern of abuse and accept responsibility for the case.**

## **A - Conducting Evaluation of Effectiveness**

Carriers perform a follow-up analysis of the provider(s) after 6 months to determine if further corrective actions are required. In some cases, it may be feasible and timely to perform the follow-up analysis of the provider before the 6 month time period. Continue monitoring the provider or group of providers until there is a referral to the fraud unit or there is evidence that the utilization problem is corrected.

## **B - Documentation for CMR Cases**

Carriers must complete and maintain a CMR summary report for each CMR case. The report should include:

- **The reason(s) the provider or group of providers was selected for review;**
- **A chronological record of all review events and actions;**
- **The information used to perform the review (e.g., relevant LMRP);**
- A record of all decisions made and all actions taken to deal with the provider's problem, including who made the decisions and the reasons for taking the actions;
- **Documentation of statistical methods used if overpayment is projected;**
- **Whenever possible, postpayment savings in terms of actual overpayment, settlement based, or statistically extrapolated;**
- **A record of all contacts with providers or beneficiaries; and**
- **Documentation of §§1879, 1870, or 1842(1) determinations.**

Retain the CMR reports for at least a 36-month period following the conclusion of a CMR case unless the RO requires a longer period.

Below is an example of a post-payment CMR summary report that carriers may use. They have the option of using an alternate format for the CMR summary report with RO approval.

## **D – Postpayment CMR Summary Report Format Example**

See exhibit 13.

## **7 – Appeal of Denials{tc "7 – Appeal of Denials"}**

A claimant dissatisfied with a contractor initial determination is entitled by law and regulations to specified appeals. The appeals process allows a provider and/or a beneficiary (or representative) the right to request a review or reconsideration of the determination to deny a service in full or in part. In this process, HOs and ALJs look to the evidence of record and must base their decision upon a preponderance of the evidence. As conclusory statements may be considered of little or questionable value, it is important that reviewers include clearly articulated

rationale for their findings. Clearly articulated rationale continues to be of importance if a denial is appealed beyond the ALJ level to the Appeals Council or eventually to federal court. Contractors must include a copy of the policy underlying denial in the case file.

## **A – Use of Medical Specialist**

In addition to the need for clearly articulated rationale, use of medical specialists will lend more weight and credibility to the rationale or findings. When an adjudicator must weigh the statements and rationale furnished by the appellant provider against the statements and rationale of the reviewer (and any information used by the reviewer), the opinion of a specialist in the same area as the provider may carry greater weight than the opinion of a nonspecialist.

Consequently, contractors are required to have a medical specialist involved in denials that are not based on the application of clearly articulated policy with clearly articulated rationale. A review or reconsideration involving the use of medical judgement should involve consultation with a medical specialist. Additionally, contractors are encouraged to use specialists whenever possible since providers are more likely to accept the opinion (and any resulting overpayment) of a specialist in their own area.

## **B – Documenting Reopening and Good Cause**

Reopening occurs when contractors conduct review of claims at any time after the initial/review determination. (See 42 CFR 405.841(a), (b), and (c).) If reopening and conducting postpayment review occur within 12 months of the initial/review determination, contractors do not need to establish good cause. However, contractors should document the date so that there is no confusion about whether good cause should have been established. After 12 months, but within 4 years from the date of the initial/review determination, contractors must establish good cause. (See MCM §§12000, 42 CFR 405.841, and 20 CFR 404.989.) Documenting the date a claim was reopened (regardless of the demand letter issue date) and the rationale for good cause when claims are reopened more than 12 months from the initial/review determination will lend credibility to contractor documentation if the determination is appealed.

### **7.1 – Reversed Denials Pending Further Action by Law Enforcement**

If a case is still pending at the OIG's, FBI's or AUSA's office and denials are reversed by an ALJ, contractors recommend to HCFA that it consider protesting the ALJ's decision to pay to the HHS Appeals Council, which has the authority to remand or reverse the ALJ's decision. Contractors should be aware, however, that ALJs are bound only by statutory and administrative law (federal regulations), HCFA rulings, and National Coverage Determinations.

The New York and Dallas HCFA ROs coordinate these protests. Contractors should consult with their ROs before initiating a protest of an ALJ's decisions. They should be aware that the Appeals Council has only 60 days in which to decide whether to review an ALJ's decisions. Thus, HCFA needs to protest the ALJ decision within 30 days of the decision, to the Appeals Council to allow the Appeals Council to review within the 60 day limit. Contractors notify all involved parties immediately if they learn that claims/claims denials have been reversed by an ALJ in a case pending prosecution.

## **8 – Overpayment Procedures**

Contractors should initiate recovery of overpayments whenever it is determined that Medicare has erroneously paid. In any case involving an overpayment, even where there is a strong likelihood of fraud, request recovery of the overpayment. Notify law enforcement of your intention to collect outstanding overpayments in cases in which you are aware of a pending investigation. There may be situations where OIG/OI or other law enforcement agencies might recommend that overpayments are postponed or not collected; however, this must be made on a case-by-case basis, and only when recovery of the overpayment would undermine the specific law enforcement actions planned or currently taking place. Contractors refer such requests to the RO. If delaying recoupment minimizes eventual recovery, delay may not be appropriate. Contractors must forward any correspondence received from law enforcement requesting the overpayment not be recovered to the RO. The RO will decide whether or not to recover. If a large number of claims are involved, contractors consider using statistical sampling to calculate the amount of the overpayment. (See MIM Part 2, §2229.B or PIM Chapter 3, §§8.1 and 8.2.)

### **8.1 – Overpayment Assessment Procedures**

After an overpayment determination is made concluding an incorrect amount of money has been paid, contractors must assess an overpayment. The assessment options vary depending upon the type of sample used when identifying beneficiary claims for inclusion in the postpay review. Whenever possible, HCFA encourages contractors to report postpayment savings in terms of:

- Actual overpayment;
- Settlement based overpayment, or
- Statistically extrapolated overpayments.

#### **A– Example Format of An Overpayment Worksheet**

Provider Name

Provider UPIN or PIN:

Reason for Review

Type of Sample Reviewed:

Statistically Valid Random  
Sample (SVRS)

Explanation of Sampling  
Methodology:

Number of Claims in Sample:

Number of Claims in Universe:

Amount of Overpayment (after allowance for deductible and coinsurance)

Claims Reviewed

Billed Amount

Allowed Amount

Rationale for Denial

§1879 Determinations

§1870 Determinations

Total Actual Overpayment

Overpayment extrapolated over the universe

### **8.1.1 – Definition of Overpayment Assessment Terms**

#### **A – Actual Overpayment**

An actual overpayment is, for those claims reviewed, the sum of payments (based on the amount paid to the provider and Medicare approved amounts) made to a provider for services which were determined to be medically unnecessary or incorrectly billed.

#### **B – Projected Overpayment**

A projected overpayment is the numeric overpayment obtained by projecting an overpayment from a SVRS to all similar claims in the universe under review.

#### **C – Limited Projected Overpayment**

A limited projected overpayment is the numeric overpayment obtained by projecting an overpayment from a limited sample or limited SVRS sub-sample to all similar claims in the universe under review.

### **8.2 – Assessing Overpayment When Review Was Based on SVRS**

If contractors chose to use a SVRS of claims for review, they calculate the valid projected overpayment. They document the sampling methodology when review is based on a SVRS. They notify the provider of the overpayment and refer the case to overpayment staff to make payment arrangements with the provider to collect the overpayment.

### **8.3 – Assessing Overpayment or Potential Overpayment When Review Was Based on Limited Sample or Limited SVRS Sub-sample**

## **Overpayment or Potential Overpayment When Review Was Based on Limited Sample or Limited SVRS Sub-sample" \l 2}**

If a limited sample or limited SVRS sub-sample of claims is chosen for review, there are three overpayment assessment options for contractors:

- Refer to overpayment staff for recoupment of the actual overpayment for the claims reviewed;
- Conduct an expanded review based on a SVRS and recoup the projected overpayment; or
- Offer the provider a consent settlement based on the potential projected overpayment amount.

### **8.3.1 – Contractor Activities to Support Assessing Overpayment{tc "8.3.1 – Contractor Activities to Support Assessing Overpayment" \l 3}**

#### **A – Step 1**

The first step in assessing an overpayment is for contractors to document for each claim reviewed the following:

- The amount of the original claim;
- The allowed amount;
- The rationale for denial;
- The §1879 determination for each assigned claim in the sample denied because the service was not medically reasonable and necessary (or the §1842(1) provider refund determination on non-assigned provider claims denied on the basis of §1862 (a)(1)(A)) (see PIM Chapter 3 §6.7 and Exhibit 14.1);
- The §1870 determination for the provider for each overpaid assigned claim in the sample (see PIM Chapter 3 §6.7 and Exhibit 14.2); and
- The amount of overpayment (after allowance for deductible and coinsurance).

#### **B – Step 2**

Notify the provider of the preliminary overpayment findings and preliminary review findings.

#### **C – Step 3**

If the provider submits additional documentation, review the material and adjust the preliminary overpayment findings, accordingly.

## **D – Step 4**

Calculate the final overpayment.

## **E – Step 5**

Refer to the overpayment recoupment staff.

### **8.3.2 – Conduct of Expanded Review Based on SVRS and Recoupment of Projected Overpayment by Contractors**

A – If an expanded review to an SVRS of claims is chosen, contractors must identify a SVRS of beneficiaries from the universe, obtain and review claims and medical records, and document for each claim reviewed:

- The amount of the original claim;
- The allowed amount;
- The rationale for denial;
- The §1879 determination for each assigned claim in the sample denied because the service was not medically reasonable and necessary (or the §1842(1) provider refund determination on non-assigned provider claims denied on the basis of §1862(a)(1)(A)) (see PIM Chapter 3 §6.7 and exhibit 14.1);
- The §1870 determination for the provider for each overpaid assigned claim in the sample (see PIM Chapter 3 §6.7 and exhibit 14.2); and
- The amount of overpayment (after allowance for deductible and coinsurance).

B – Contractors calculate the projected overpayment by extrapolating from the actual overpayment to the universe that excludes those claims determined that the provider did not have knowledge that the service was not medically necessary;

C – Notify the provider of the preliminary projected overpayment findings and review findings;

D – If the provider submits additional documentation, review the material and adjust the preliminary projected overpayment findings, accordingly;

E – Calculate the final overpayment; and

F – Refer to the overpayment recoupment staff.

**See Exhibit 8 – Recovery of Overpayment and Corrective Actions**

### **8.3.3 – Consent Settlement Instructions{tc "8.3.3 – Consent Settlement Offer Based on Potential Projected Overpayment" \l 3}**

The consent settlement process is an appropriate tool to modify a provider's billing practice while limiting contractor costs in monitoring provider practice patterns. Consent settlement documents carefully explain, in a neutral tone, what rights a provider waives by accepting a consent settlement. Also, the documents must explain in a neutral tone the consequences of not accepting a consent settlement. A key feature of a consent settlement is a binding statement that the provider agrees to waive any rights to appeal the decision regarding the potential overpayment. The consent settlement agreement must carefully explain this to ensure that the provider is knowingly and intentionally agreeing to a waiver of rights. A consent settlement correspondence must contain:

- A complete explanation of the review and the review findings;
- A thorough discussion of §§1879 and 1870 determinations where applicable; and
- The consequences of deciding to accept or decline a consent settlement.

When offering a provider a consent settlement, contractors may choose to present the consent settlement letter to the provider in a face-to-face meeting. The consent settlement correspondence describes the three options available to the provider.

#### **A – Option 2 - Acceptance of Potential Projected Overpayment**

Providers selecting Option 2 agree to refund the entire limited projected overpayment amount without submitting additional documentation. These providers forfeit their right to appeal the adjudication determinations made on the sampled cases and the potential projected overpayment that resulted from extrapolating to the universe. For providers who elect Option 1, do not audit any additional claims for the service under review within the time period audited. (Waive Option 2 if you so desire.)

#### **B – Option 1- Acceptance of Capped Potential Projected Overpayment**

Providers selecting Option 1 agree to submit additional pre-existing documentation. Review this additional documentation and adjust the potential projected overpayment amount accordingly. Do not audit any additional claims for the service under review within the time period audited for providers who elect Option 1.

#### **C – Option 3 - Election to Proceed to SVRS**

If a provider fails to respond, this option is selected by default. For providers who select this option knowingly or by default, thereby rejecting the consent settlement offer and retaining their full appeal rights, contractors must:

- Notify the provider of the actual overpayment and refer to overpayment recoupment staff. (See PIM Chapter 3 §8); and

- Initiate an expanded review of a SVRS of the provider's claims for the service under review. (See PIM Chapter 3 §8.3.2)

If the review results in a decision to recoup overpayment through the consent settlement process, the consent settlement must have been initiated within 12 months of the selection process.

**A sample of Consent Settlement Documents can be found in Exhibit 15.**

## **8.4 – Voluntary Repayment During an Active Fraud Investigation**

If a provider offers to make payment in a case under investigation, contractors contact OIG/OI immediately. OIG/OI contacts the U. S. Attorney's Office and requests clearance to accept payment. If the AUSA believes that repayment jeopardizes any criminal prosecution of the provider, OIG/OI confirms in writing the AUSA's instructions regarding the rejection of the repayment offer. If the AUSA does not object to a repayment, accept the overpayment contingent upon the provider signing an agreement. The agreement specifies the claims covered by such an overpayment and includes language to the effect that the provider acknowledges the Government's right to pursue any appropriate additional criminal, civil, and administrative remedies.

Contractors use the following language when a provider repays money in the course of any investigation:

"The acceptance of payment from \_\_\_\_\_ of the sum of \$ \_\_\_\_\_ as repayment for the claims specified herein in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

If the overpayment is accepted, contractors deposit the funds into the Federal Health Insurance Benefits Accounts (FHIBA). Do not establish a separate escrow account to segregate funds received from a provider suspected of fraudulent conduct from other deposits received (whether at the same banking establishment or otherwise). Realize the benefits of such deposits by receiving an earnings credit on balances maintained in the account(s). (This earnings credit helps to offset any bank services charges for handling the Medicare account.) Further, apply earnings credit to payment of interest on Medicare underpayments as stipulated in §§1815(d) and 1833(j) of the Act.

Refer any contacts (personal, letter, or telephone) by the suspect or his/her legal representative related to the investigation to OIG/OI, once the case has been accepted by OIG/OI. This applies to all contacts after being advised that OIG/OI has instituted an active fraud investigation involving a particular provider even if the case has been referred to a U. S. Attorney; however, this does not pertain to routine claim processing issues.

**Exception Where Provider Furnishes Service "Under Arrangements":**

An exception may be made where a provider furnishes services "under arrangements" with suppliers of services who are independent practitioners. Such suppliers include, but are not limited to, physical therapists, inhalation therapists, and speech therapists.

If the supplier is under investigation for alleged fraudulent practices, but there is no complicity by the provider, proceed to final settlement on the provider's cost report, including recoupment of any overpayments involving services by the supplier. This recovery is not damaging to the prospects of a successful criminal or civil action. Direct questions concerning arrangements of this type to OIG/OI.

### **8.5 - Coordination with Audit and Reimbursement Staff**

Intermediary MR staff must work closely with their Audit/Reimbursement staff from the beginning of the postpay process to ensure that the universe selected is appropriate and that overpayments and underpayments are accurately determined and reflected on the provider's cost report. They furnish the Audit/Reimbursement staff the following information upon completion of the postpayment review:

- The sample documentation contained in PIM Chapter 3, §6.3.2;
- The identification of incorrectly paid or incorrectly denied services; and
- All other information required by the Cost Report Worksheets in PIM Chapter 3, §§6.3.7, 6.3.8, 6.3.9, and 6.3.10 for the specific provider type they are reviewing.

They also furnish the above information if adjustments are made as a result of appeals. (See PIM Chapter 3, §§6.3.5.)

In most instances, the Audit/Reimbursement staff will:

- Determine the overpayment to be recovered based on MR findings and pursue the recovery of the overpayment; and
- Use the information MR provides on their postpayment review findings to ensure an accurate settlement of the cost report and/or any adjustments to interim rates that may be necessary as a result of the MR findings. To preserve the integrity of Provider Statistical and Reimbursement Report (PS&R) data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, the same data must be used when the projection is made as was used when the sample was selected. **Individual claims will not be adjusted.** In the event that a cost report has been settled, Audit/Reimbursement staff will determine the impact on the settled cost report and the actions to be taken.

Projections on denied services must be made for each discipline and revenue center

When notifying the provider of the review results for cost reimbursed services, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost report settlement to reflect final settled costs.

Information from the completed Worksheets 1 - 7 must be routed to the Audit and Reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the number of denied services (actual denied services plus projected

denied services) for each discipline and the amounts of denied charges (actual denied amounts plus projected denied amounts) for supplies and drugs.

Upon completion of the review, furnish the Audit and Reimbursement staff with the information listed in PIM Chapter 3 §6.3D.

## **9 – Suspension of Payment {tc "9 – Suspension of Payment" }**

Medicare authority to withhold payment in whole or in part for claims otherwise determined to be payable is found in federal regulations at 42 CFR 405.370-377, which provides for the suspension of payments.

### **9.1 – When Suspension of Payment May Be Used {tc "9.1 – When Suspension of Payment May Be Used" \l 2}**

Suspension may be used when the contractor possesses reliable information that:

- Fraud or willful misrepresentation exists;
- An overpayment exists but the amount of the overpayment is not yet determined;
- The payments to be made may not be correct; or
- The provider fails to furnish records and other requested information.

These four reasons for implementing a suspension of payment are described more fully below.

**NOTE:** For intermediary providers that file cost reports, suspension may have little impact. If the provider is receiving periodic interim payments (PIP), interim payments may be suspended. If the provider is not on PIP, suspension will affect the settlement of the cost report. When an overpayment is determined, the amount is not included in any settlement amount on the cost report. For example, if the intermediary has suspended \$100,000, when the cost report is settled, the intermediary would continue to hold the \$100,000. This means if the cost report shows HCFA owing the provider \$150,000, the provider would only receive \$50,000 until the suspension action has been completed. If the provider owes HCFA money at settlement, the amount of the suspended payment would increase the amount owed by the provider. In most instances, intermediaries should adjust interim payments to reflect projected cost reductions. Limit the adjustment to the percentage of potential fraud or the total payable amount for any other reasons. For example, if the potential fraud involved 5 percent of the interim rate, the reduction in payment is not to exceed 5 percent. Occasionally, suspension of all interim payments may be appropriate.

#### **9.1.1 – Fraud or Willful Misrepresentation Exists - Fraud Suspensions {tc "9.1.1 – Fraud or Willful Misrepresentation Exists - Fraud Suspensions" \l 3}**

Suspension of payment may be used when the contractor possesses reliable information that fraud or willful misrepresentation exists. For the purposes of this section, these types of suspensions will be called “fraud suspensions.”

Fraud suspensions may be imposed for reasons not typically viewed within the context of false claims. An intermediary example is that the PRO has reviewed inpatient claims and determined that the Diagnosis Related Groups (DRGs) have been upcoded. An example carriers may find is that suspected violation of the physician self-referral ban is cause for suspension since claims submitted in violation of this statutory provision must be denied and any payment made would constitute an overpayment. Forged signatures on CMN, treatment plans, and other misrepresentations on Medicare claims and claim forms to obtain payment result in overpayments. Credible allegations of such practices are cause for suspension pending further development.

Whether or not to recommend suspension action is a case-by-case decision requiring review and analysis of the allegation and/or facts. The following information is provided to assist the contractor in deciding whether or not to recommend suspension action.

## **A – Complaints**

Contractors have considerable latitude with regard to complaints alleging fraud and abuse. The history, or newness of the provider, the volume and frequency of complaints concerning the provider, and the nature of the complaints all contribute to whether suspension of payment should be recommended. If there is a credible allegation(s) that a provider is submitting or may have submitted false claims, recommend suspension of payment to the RO.

## **B – Provider Identified in HCFA Fraud Alert**

Contractors recommend suspension to the RO if a provider in their jurisdiction is the subject of a HCFA national fraud alert and the provider is billing the identical items/services cited in the alert or if payment for other claims must be suspended to protect the interests of the government.

## **C – Requests from Outside Agencies**

Contractors follow the suspension of payment actions for each agency request indicated below.

- HCFA -- Initiate suspension as requested.
- OIG/FBI -- Forward the written request to the HCFA RO for its review and determination. The RO will decide.
- AUSA/DOJ -- Forward the written request to the HCFA RO for its review and determination.
- Other – Other situations the contractor may consider recommending suspension of payment to the RO are:

- **Provider has pled guilty to, or been convicted of, Medicare, Medicaid, CHAMPUS, or private health care fraud and is still billing Medicare for services;**
- Federal/State law enforcement has subpoenaed the records of, or executed a search warrant at, a health care provider billing Medicare;
- Provider has been indicted by a Federal Grand Jury for fraud, theft, embezzlement, breach of fiduciary responsibility, or other misconduct related to a health care program;
- Provider presents a pattern of evidence of known false documentation or statements sent to the contractor; e.g., false treatment plans, false statements on provider application forms.

### **9.1.2 – Overpayment Exists But the Amount is Not Determined - General Suspensions**

Suspension of payment may be used when the contractor possesses reliable information that an overpayment exists but has not yet determined the amount of the overpayment. For the purposes of this section, these types of suspensions will be called “general suspensions.”

**EXAMPLE:** Several claims identified on post-pay review were determined to be non-covered or miscoded. The provider has billed this service many times before and it is suspected that there may be a number of additional non-covered or miscoded claims that have been paid. Suspension action may be initiated.

### **9.1.3 – Payments to be Made May Not be Correct - General Suspensions**

Suspension of payment may be used when the contractor possesses reliable information that the payments to be made may not be correct. For the purposes of this section, these types of suspensions will be called “general suspensions”

**EXAMPLE:** The contractor believes that the provider may be submitting non-covered or miscoded claims but the contractor lacks the resources at this point in time to perform manual prepay review on all the provider’s claims. Suspension action may be appropriate.

### **9.1.4 – Provider Fails to Furnish Records and Other Requested Information - General Suspensions**

Suspension of payment may be used when the contractor possesses reliable information that the provider has failed to furnish records and other information requested or is due. For the purposes of this section, these types of suspensions will be called “general suspensions”.

**EXAMPLE 1:** During a postpayment review, medical records and other supporting documentation are solicited from the provider to support payment. The provider fails to submit the requested records. The contractor determines that the provider is continuing to submit claims for services in question. Recommending suspension may be appropriate.

**EXAMPLE 2:** Provider fails to submit its cost report on time. Recommend immediate suspension without advance notice.

## **9.2 – Procedures for Implementing Suspension of Payment{tc "9.2 – Procedures for Implementing Suspension of Payment" \l 2}**

### **9.2.1 – HCFA Approval{tc "9.2.1 – HCFA Approval" \l 3}**

The initiation (including whether or not to give advance notice), modification, or removal of any type of suspension requires the explicit prior approval of the HCFA RO. The designated approving authority in the RO will seek the advice of the Regional Chief Counsel's Office (RCCO) and coordinate suspension action with its law enforcement partners as it deems appropriate.

The contractor must forward a draft of the proposed provider notice of suspension and a brief summary of the evidence upon which the recommendation is based to the RO. It does not take suspension action without the explicit approval of the resident RO. In most cases, the RO will notify OIG and other law enforcement partners of its decision and will keep law enforcement apprised of any future decisions to modify the suspension. However, if a contractor has been working with law enforcement on the case, immediately notify them of the recommendation to the RO. Notice may consist of a telephone call or a fax if there is a need to expedite suspension. If law enforcement wants more time to study or discuss the suspension, discuss their request with the RO. If law enforcement requests that suspension action should, or should not, be taken, contractors advise them to contact the RO. They also advise them that the request must be in writing and must provide a detailed rationale justifying why payment should, or should not, be suspended.

### **9.2.2 – The Notice of Intent to Suspend{tc "9.2.2 – The Notice of Intent to Suspend" \l 3}**

#### **9.2.2.1 – Prior Notice Versus Concurrent Notice{tc "9.2.2.1 – Prior Notice Versus Concurrent Notice" \l 4}**

Contractors must always inform the provider of the suspension action being taken. Under most circumstances, give at least 15 calendar days prior notice. Day one begins the day after the notice is mailed. This is applicable to general suspensions and to fraud suspensions.

However, if the Medicare Trust Fund would be harmed by giving prior notice, contractors recommend that the RO waive the prior notice requirement. If the RO waives the prior notice requirement, contractors send the provider notice concurrent with implementation of the suspension, but no later than 15 days after suspension is imposed.

With respect to fraud suspensions, contractors recommend that the RO not give prior notice if such notice, in the contractor's opinion, any of the following apply:

1. Delay in suspension will cause the overpayment to rise at an accelerated rate (i.e., dumping of claims);
2. There is reason to believe that the provider may flee the contractor's jurisdiction before the overpayment can be recovered; and
3. The contractor has first hand knowledge of a risk that the provider will cease or severely curtail operations or otherwise seriously jeopardize its ability to repay its debts.

If the RO waives the advance notice requirement, send the provider notice concurrent with implementation of the suspension, but no later than 15 days, after suspension is imposed.

#### **9.2.2.2 – Content of Notice**

Contractors prepare a “draft notice” and send it, along with the recommendation, to the RO for approval. In the notice, inform the provider:

- That suspension action will be imposed;
- That suspension action is not appealable;
- When suspension will begin;
- The items or services affected;
- How long the suspension is expected to be in effect;
- The reason for suspending payment; and
- That the provider has the opportunity to submit a rebuttal statement to the contractor within 15 days of notification.

In the notice, contractors let the provider know why the suspension action is being taken. For fraud suspensions, the contractor should do so in a way that does not disclose information that would undermine a potential fraud case. However, indicating that payment is being suspended because fraud is suspected **is not** sufficient rationale. The rationale must be specific enough to justify the action being taken and allow the provider an opportunity to identify the problem. (Model notice letters are provided in PIM Exhibit 16 For illustrative purposes, Model Letter 16B includes examples of the level of specificity contractors should use in explaining reasons for suspending payment.)

#### **9.2.2.3 – Shortening the Notice Period for Cause**

At any time, the contractor may recommend to the RO that the advance notice be shortened **during** the notice period. Such a recommendation would be appropriate if the contractor believes that the provider is intentionally submitting additional claims in anticipation of the effective date of the suspension. If suspension is imposed earlier than indicated in the notice, notify the provider in writing of the change and the reason.

#### **9.2.2.4 – Mailing the Notice to the Provider**

After consultation with and approval from the RO, contractors send the notice of suspension to the provider. In the case of fraud suspensions, they send a copy to the OIG, FBI, or AUSA if they have been previously involved.

#### **9.2.2.5 – Opportunity for Rebuttal**

The suspension notice gives the provider an opportunity to submit to the contractor a statement indicating why suspension action should not be, or should not have been, imposed. A provider's reaction to suspension may include threats of court action to restore payment or to stop the proposed action. Contractors forward provider responses to the HCFA RO as soon as possible. The RO will consult with OGC and will advise the contractor before the contractor responds to any rebuttal statements.

Contractors should ensure the following:

- Timing – Implementation of suspension actions is not delayed by the receipt and/or review of the rebuttal statement. The suspension goes into effect as indicated in the notice.
- Review of Rebuttal – Because suspension actions are not appealable, the rebuttal is the provider's only opportunity to present information as to why suspension action should be non-initiated or terminated. Contractors must carefully review the provider's rebuttal statement and consider all facts and issues raised by the provider. If the contractor is convinced that the suspension action should be non-initiated or terminated, consult immediately with the RO before taking such action.
- Response – Respond to the provider's rebuttal within 15 days from the date the statement is received, following consultation with the RO.

#### **9.2.3 – Claims Review and Case Development During the Suspension Period**

##### **9.2.3.1 – Claims Review**

Once suspension has been imposed, contractors follow normal claims processing and MR procedures. Contractors make every attempt within the MR budget to determine if suspended claims are payable. They ensure that the provider is not substituting a new category of improper

billing to counteract the effect of the payment suspension. If the claim is determined to be not payable, it must be denied. For claims that are not denied, they send a remittance advice to the provider showing that payment was approved but not sent. Contractors follow procedures in the PIM Chapter 3, §8 in establishing an overpayment. The overpayment consists of all claims in a specific time period determined to have been paid incorrectly. Contractors make all reasonable efforts to expedite the determination of the overpayment amount.

**NOTE:** Claims selected for postpayment review may be reopened within 1 year for any reason or within 4 years for good cause. Cost report determinations may be reopened within 3 years after the Notice of Program Reimbursement has been issued. Good cause is defined as new and material evidence, error on the face of the record, or clerical error. The regulations have open-ended potential for fraud or similar fault. The exception to the 1-year rule is for adjustments to DRG claims. A provider has 60 days to request a change in an assignment of a DRG. (See 42 CFR 412.60(d).)

### **9.2.3.2 – Case Development**

Even though suspension action was recommended and/or implemented, contractors discuss the case with the OIG to ascertain their interest in working the case. If OIG declines the case, they discuss whether OIG referral to another law enforcement agency is appropriate. If law enforcement is not interested in the case, contractors consider preparing the case for CMP or permissive exclusion. See PIM Chapter 3 §12. Whether the case is accepted by law enforcement or not, contractors develop the overpayment as expeditiously as administratively feasible and keep law enforcement apprised of the dollars being withheld as well as any potential recoupment action if they are investigating the provider under suspension.

The contractor must enter information on the case and the suspension in the FID ACTION screen, no later than the effective date of suspension. Update the amount being withheld at least every 30 days. Show in the FID the effective date of the suspension, the items/services affected, the amount of money withheld to date, and the date the suspension is lifted. Always indicate whether the money withheld was ultimately paid or used to recoup the overpayment. Include in the ACTION screen report whether the suspension was initiated at the request of law enforcement.

### **9.2.4 – Duration of Suspension of Payment**

#### **A – General Requirements**

The RO will initially approve suspension for a period up to 180 days. The RO may extend the period of suspension for up to an additional 180 days upon the written request of the intermediary, carrier, OIG, or other law enforcement agency. The request must provide:

- Name and address of the provider under suspension;
- Amount of additional time needed (not to exceed the 180 days); and
- Rationale explaining why the additional time is necessary.

## **B – Exceptions to Time Limits**

The following exceptions may apply:

- Department of Justice (including U.S. Attorneys). The RO may grant an additional extension to the Department of Justice if it submits a written request. Requests must include: 1) the identity of the person or entity under suspension, 2) the amount of time needed for continued suspension in order to implement an ongoing or anticipated criminal and/or civil proceeding, and 3) a statement of why and/or how criminal and/or civil actions may be affected if the suspension is not extended. This extension may be granted based on a request received by the RO at any time before or during the period of suspension.
- OIG. The time limits in the PIM Chapter 3 §9.2.4A above do not apply if the case has been referred to and is being considered by OIG for administrative sanctions (CMPs). However, this exception does not apply to pending criminal investigations by OIG.

## **C – Provider Notice of the Extension**

Following consultation with the RO and as soon as is administratively feasible, contractors notify the provider that the suspension action has been extended.

### **9.2.5 – Removing the Suspension**

Contractors recommend to the RO that suspension of payments be terminated at such time as the time limit expires or earlier if any of the following apply:

A – If the basis for the suspension action was that an overpayment existed but the amount of the suspected overpayment is not yet determined, terminate the suspension before the time limit has expired when:

- No overpayment was identified;
- The amount of suspected overpayment has been determined and it is no longer accruing; or
- The amount of the suspended monies exceeds the estimated amount of the suspected overpayment.

B – If the basis for the suspension action was that fraud or willful misrepresentation existed, terminate the suspension before the time limit has expired when there is satisfactory evidence that the fraud activity has ceased.

C – If the basis for the suspension action was that payments to be made may not be correct, terminate the suspension before the time limit has expired when there is certainty that payments to be made are correct.

D – If the basis for the suspension action was that the provider failed to furnish records or cost report, terminate the suspension before the time limit has expired if the provider has submitted

all previously requested records and the contractor believes the provider will comply with future requests for records.

Inform the provider of the determination to remove the suspension of payments.

### **9.2.6 – Disposition of the Suspension**

Payments for appropriate Medicare claims that are withheld during a suspension should not exceed the suspected amount of overpayment. Contractors maintain an accurate, up-to-date record of the amount withheld and the claims that comprise the suspended amount. Interest accrues on payment suspended in accordance with 42 CFR 405.378. Contractors keep a separate accounting of payment on all claims affected by the suspension. They keep track of how much money is uncontested and due the provider. The amount needs to be known as it represents assets that may be used to recoup any overpayment. (See PIM Chapter 3, §8.) Contractors must be able to provide, upon request, copies of the claims affected by the suspension. After the suspension has been removed, they apply the amount withheld first to the overpayment. This is used to be referred to as “offset.” Contractors remit to the provider all monies held in excess of the amount the provider owes. If the provider owes more money than was held in suspension, they initiate recoupment action.

### **9.2.7 – Contractor Suspects Additional Improper Claims**

#### **A – Present Time**

If the contractor believes that the provider will continue to submit non-covered, misrepresented, or potentially fraudulent claims, it considers implementing other actions as appropriate (e.g., prepayment review, a new suspension of payment.)

#### **B – Past Period of Time**

If the contractor believes there are past periods of time that may contain possible overpayments, contractors may consider implementing a new suspension of payment covering those dates.

#### **C – Additional Services**

During the time that a provider is under suspension of payment for a particular service(s), if it is determined there is reason to initiate suspension action for a different service, a new suspension of payment must be initiated.

Anytime a new suspension action is initiated on a provider who is already under one or more suspension actions, contractors obtain separate HCFA approval, issue an additional notice to the provider, offer a new rebuttal period, etc.

### **9.3 – Suspension Process for Multi-Region Issues**

### **9.3.1 – DMERCs**

The DMERCs should initiate suspension action when one of the criteria listed above is identified. (See PIM Chapter 3 §9.1, When Suspension of Payment May Be Used.) The following details the process that should be followed when one DMERC suspends payments.

A – The initiating DMERC will get the approval of its lead RO. HCFA's RO have agreed to support the decision of another RO.

B – The initiating DMERC will share the suspension of payment information with all of the other DMERCs. Reliable information that payments should be suspended in one region is sufficient reason for suspension decisions to apply to the other regions.

C – The lead RO will issue one suspension letter on HCFA letterhead advising that payments will be held by all four DMERCs. This letter will advise the supplier to contact the initiating DMERC should the supplier have any questions.

D – Should the suspension action require an extension of time, the lead RO will send an extension letter to the supplier.

### **9.3.2 – Other Multi-Regional Contractors**

In some situations, more than one HCFA RO may be involved. For example, both the Seattle (resident RO) and Kansas City (RHHI RO) have jurisdiction in Idaho. Where there are multiple ROs, it is incumbent on the ROs (not the contractors) to reach consensus on suspension action and to provide a single point of contact at the resident RO for the contractor. In other words, it is usually the RO that services the geographic State or area where the beneficiary and providers are located that would be responsible for coordinating HCFA's decision and contacts with interested law enforcement agencies.

**Model Suspension of Payment Letters can be found in Exhibit 16.**

## **10 – Referral of Cases to Other Entities for Action**

### **10.1 – Referral of Cases to OIG/OI**

A strong potential for fraud exists when a review results in 40 percent of beneficiaries contacted during the review (including initial complainant) denying having received services billed by the provider. These should be individuals who are capable of reliably giving the information.

If a case is referred to OIG/OI for full-scale investigation with less than 40 percent beneficiary denial of having received billed services, but in the contractor's opinion there is a strong potential for fraud, OIG/OI has final approval whether the case is to be considered for further

investigation. However, if the OIG/OI determines in a particular case that the percent is different from the 40 percent, contractors use the percent it establishes.

Carriers and FIs have a duty to identify cases of suspected fraud and to make referrals of all such cases to the OIG, regardless of dollar thresholds or subject matter. Matters should be referred when the contractor has a reasonable basis to suspect that the provider (a) intentionally engaged in improper billing, (b) submitted improper claims with actual knowledge of their falsity, or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. In cases where providers' employees submit complaints, such cases should be forwarded to the OIG immediately.

If a case has been referred to OIG/OI, OIG/OI has 90 calendar days to accept the referral, refer the case to the DOJ (for example, the FBI, AUSAs, etc.), or to reject the case. If the contractor does not hear from OIG/OI within the 90-day time frame, the contractor should follow-up with OIG/OI to determine if they are going to accept the case. When the contractor contacts the OIG to inquire whether the OIG will accept a case referral, the contractor should document the call as a referral in the FID, including subsequent acceptance or rejection documentation of the case. Discuss the case during periodic meetings with law enforcement. If OIG/OI will not give a definite answer, contact the RO for assistance. If OIG/OI does not accept the case or is still unwilling to render a decision on the case, even after the intercession of the RO, contractors proceed with action to ensure the integrity of the Medicare Trust Funds. Contractors should continue to obtain and develop necessary information to develop a quality case referral, including taking steps to ensure that they have a complete picture, within their resources and authority, of the extent and nature of the possible fraudulent activity.

OIG/OI will usually exercise one or more of several options when deciding whether to accept a case as follows:

- Conduct a criminal and/or civil investigation;
- Refer the case back to the contractor for administrative action/recovery of overpayment with no further investigation;
- Refer the case back to the contractor for administrative action/recoupment of overpayment after conducting an investigation or after consulting with the appropriate AUSA's office;
- Refer the case back to the contractor for administrative action/recoupment of overpayment after the AUSA's office has declined prosecution; and
- Refer the case to another law enforcement agency for investigation.

Where OIG/OI conducts an investigation, OIG/OI will usually initiate ongoing consultation and communication with the contractor to establish evidence (i.e., data summaries, statements, bulletins, etc.) that a statutory violation has occurred.

In addition to referral of such cases to the OIG, contractors should also identify and take additional corrective action and prevent future improper payment (for example, by placing the provider or supplier's claims on pre-payment review). In every instance, whether or not the case is a potential law enforcement referral, the first priority is to minimize the potential loss to the

Medicare Trust Funds and to protect Medicare beneficiaries from any potential adverse effect. Appropriate action varies from case to case. In one instance, it may be appropriate to suspend payment pending further development of the case. In another instance, suspending payment may alert the provider to detection of the fraudulent activity and undermine a covert operation already underway, or being planned, by Federal law enforcement. Contractors should consult appropriately with the OIG when taking such measures. The OIG may provide the contractor with information that should be considered in determining what corrective actions should be taken.

It is important to alert OIG/OI, FBI, both the civil and criminal divisions in the U.S. Attorney's Office, and the RO of contemplated suspensions, denials, and overpayment recoveries where there is reliable evidence of fraud and a referral pending with the OIG/OI or FBI, or a case pending in a U.S. Attorney's Office.

If the case is the focus of a national investigation, contractors never take any action without first clearing it with the RO and the agency that has the lead for the investigation.

### **10.1.1 – Referral of Potential Fraud Cases Involving Railroad Retirement Beneficiaries**

The Railroad Retirement Board (RRB) OIG has jurisdiction over investigations involving RRB beneficiaries. Contractors refer these cases to OIG/OI that, in turn, will notify RRB OIG.

When it is necessary for OIG to contact United Health Care in its capacity as RRB's carrier, they notify the RRB central office before contacting the appropriate United Health Care Regional Claims Processing Center.

RRB personnel occasionally can more readily obtain necessary information from beneficiaries, e.g., working through the social security office when the Part B beneficiary is a railroad annuitant with no SSA monthly benefit involvement. When suspected violations come to the attention of United Health Care in its processing of claims, it is expected to check for the possibility of similar violations in Medicare claims processed for RRB as well.

When another Medicare carrier identifies a possible fraud or abuse situation and is attempting to ascertain from in-house material whether development is warranted, it contacts the appropriate United Health Care Regional Claims Processing Center, prior to contacting OIG/OI, to ascertain whether United Health Care has had any problems with the subject. If United Health Care identifies a possible PI situation, it contacts the Medicare area carrier to obtain information on any prior problems and forwards the information directly to OIG/OI. This direct contact between carriers is appropriate if attempting to determine whether to report a situation to Office of Investigations Field Office (OIFO). United Health Care notifies the RRB office in Chicago of such contact with OIFO.

### **10.1.2 – Cases Requiring Immediate Referral to OIG/OI**

The contractor should immediately advise OIG/OI when allegations with one or more of the characteristics shown below are received. All available information must be forwarded, unless directed otherwise by OIG/OI.

- Indications of contractor employee fraud;
- Cases involving an informant that is an employee or former employee of the suspect physician or supplier;
- Involvement of providers with prior convictions for defrauding Medicare or who are currently the subject of an OIG fraud investigation;
- Situations involving the subjects of current program investigations;
- Multiple carriers involved with any one provider (OIFO coordinates activities with all involved carriers);
- Cases with, or likely to get, widespread publicity or involving sensitive issues;
- Allegations of kickbacks or bribes or a crime by a Federal employee;
- Indications that organized crime may be involved; or
- Indications of fraud by a third party insurer that is primary to Medicare.

### **10.1.3 – Contractor Actions When Cases Are Referred to and Accepted by OIG/OI**

Even though OIG/OI or another law enforcement agency has accepted a case, it is incumbent on the contractor to continue to monitor and document the suspect provider's activities. Additional complaints or other information received should be immediately forwarded to the appropriate agency. Also, contractors may still take action to suspend payments, deny payments, or to recoup overpayments.

#### **10.1.3.1 – Suspension**

If payment has not been suspended before OIG/OI accepts the case, contractors discuss suspending payments with OIG/OI where there is reliable and substantive evidence that overpayments have been made and are likely to continue. (See PIM Chapter 3, §9.) Where OIG/OI disagrees with the suspension on the grounds that it will undermine their law enforcement action and there is disagreement, contractors discuss the matter with the RO. The RO will then decide, after consulting with OIG/OI, whether contractors should proceed with the suspension. Suspension of payment should not be delayed in order to increase an overpayment amount in an effort to make the case more attractive to law enforcement.

Continuing to pay claims submitted by a suspect provider for this purpose is not an acceptable reason for not suspending payment.

## **A – Record of Suspended Payments Regarding Providers Involved in Litigation**

Contractors provide OIG/OI with current information, as requested, regarding total payments due providers on monies that are being withheld because those cases are being referred for fraud prosecution. (The OIG/OI sends notification of which potential fraud cases have been referred for prosecution.) These monies represent potential assets against which offset is made to settle overpayments or to satisfy penalties in any civil action brought by the Government. The total amount of withheld payments is also pertinent to any determination by the DOJ whether civil fraud prosecution action is pursued or a negotiated settlement attempted.

### **10.1.3.2 – Denial of Payments for Cases Referred to and Accepted by OIG/OI{tc "10.1.3.2 – Denial of Payments for Cases Referred to and Accepted by OIG/OI" \l 4}**

Where it is clear that the provider has not furnished the item or services, denial is the appropriate action. (See PIM Exhibit 14.) Before denying payments, contractors consult with the RO.

### **10.1.3.3 – Recoupment of Overpayments{tc "10.1.3.3 – Recoupment of Overpayments" \l 4}**

Contractors seek to recoup overpayments whenever there is a determination that Medicare has erroneously paid. Once an overpayment has been determined, the statute and regulations require that the overpayment be recovered, especially if the overpayment is not related to the matter that was referred to law enforcement. (See PIM Chapter 3, §8.)

### **10.1.4. – OIG/OI Case Summary and Referral{tc "10.1.4. – OIG/OI Case Summary and Referral" \l 3}**

Contractors should use the following format when preparing summaries for referral to OIG/OI where additional criminal, CMPL or sanctions action appears appropriate. They retain a copy of the summary in the case file.

**A Case Referral Fact Sheet Format can be found in Exhibit 16.1.**

**A Case Summary Format can be found in Exhibit 16.2.**

### **10.1.5 – Actions to be Taken When A Fraud Case is Refused by OIG/OI{tc "10.1.5 – Actions to be Taken When A Fraud Case is Refused by OIG/OI" \l 3}**

#### **10.1.5.1 – Continue to Monitor Provider and Document Case File{tc "10.1.5.1 – Continue to Monitor Provider and Document Case File" \l 4}**

Contractors do not close a case simply because it is not accepted by OIG/OI. Since the subject is likely to continue to demonstrate a pattern of fraudulent activity, they should continue to monitor

the situation and to document the file, noting all instances of suspected fraudulent activity, complaints received, actions taken, etc. This will strengthen the case if it is necessary to take further administrative action or there is a wish to resubmit the case to OIG/OI at a later date. If contractors do resubmit the case to OIG/OI, they should be certain to highlight the additional information collected and the increased amount of money involved.

If OIG/OI declines a case, contractors send a warning notice to the provider. They inform the provider that there is reason to believe that false claims have been submitted. They must be clear that claims will continue to be monitored, and if the inappropriate practice continues, the case will be forwarded to OIG/OI. They document all contacts with the provider.

### **10.1.5.2 – Take Administrative Action on Cases Referred to and Refused by OIG/OI**

Contractors take immediate action to implement appropriate administrative remedies, including the suspension or denial of payments, and the recovery of overpayments. (See PIM Chapter 3, §§7 and 8.) Because the case has been rejected by law enforcement, they only consult with the RO concerning the imposition of suspension. They pursue administrative and/or civil sanctions by OIG where law enforcement has declined a case.

### **A – Denial/Referral Action for Erroneous Payment(s), Cases Not Meeting the Referral Threshold**

Many instances of erroneous payments cannot be attributed to fraudulent intent. There will also be cases where there is apparent fraud, but the case has been refused by law enforcement. Where there is a single claim, contractors deny the claim and collect the overpayment. Where there are multiple instances, they deny the claims, collect the overpayment, and warn the provider. Contractors refer the provider, as appropriate, to provider relations, medical review, audit, etc.

### **10.1.5.3 – Refer to Other Law Enforcement Agencies**

If the OIG/OI declines a case that the contractor believes has merit, the contractor may refer the case to other law enforcement agencies, such as the FBI, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), RRB/OIG, and/or the MFCU. The contractor must inform the OIG/OI if its intent to do so.

Contractors pursue recommending administrative and/or civil sanctions by OIG where law enforcement has declined the case. They consider referring the case to OIG through OIG/OI for exclusion.

### **10.2 – Referral to State Agencies or Other Organizations**

Contractors refer instances of apparent unethical or improper practices or unprofessional conduct to State licensing authorities, medical boards, the PRO, or professional societies for review and possible disciplinary action. If a case requires immediate attention, they refer it directly to the

State licensing agency or medical society and send a copy of the referral to the PRO. (See PIM Chapter 3 §10.3.)

Some State agencies may have authority to terminate, sanction, or prosecute under State law. It may be appropriate to refer providers to the State licensing agency, the MFCU, or any other administrative agency willing and able to sanction providers that either bill improperly or mistreat their patients. (See PIM Chapter 3, §10.1.5.3 and §11.) This option is strongly recommended in instances where a Federal law enforcement is not interested in the case.

In each State there is a Medicare survey and certification agency. It is typically within the Department of Health. The survey agency has a contract with HCFA to survey and certify institutional providers as meeting or not meeting applicable Medicare health and safety requirements, called Conditions of Participation. Providers not meeting these requirements are subject to a variety of adverse actions ranging from bans on new admissions to termination of their provider agreements. These administrative sanctions are imposed by the RO, typically after an onsite survey by the survey agency.

Ordinarily, contractors do not refer isolated instances of questionable professional conduct to medical or other professional societies and State licensing boards. However, in flagrant cases, or where there is a pattern of questionable practices, a referral is warranted. The MR and fraud units must always confer before such referrals, to avoid duplicate referrals. There is no need to compile sufficient weight of evidence so that a conclusive determination of misconduct is made prior to the referral. Rather, contractors ascertain the probability of misconduct, gather available information, and leave any further investigations, review, and disciplinary action to the appropriate professional society or State board. Consultation and agreement between the MR and fraud unit are to precede any referral to these agencies.

The fraud unit should work closely with their RO fraud and abuse coordinator on these referrals. The fraud coordinator will involve the necessary staff in the OCSQ, the RCCO and staff in the Center for Medicaid and State Operations (CMSO). Involving OCSQ and CMSO is essential since these components would be involved in any adverse action taken against the provider.

Concurrently, contractors notify OIG/OI and the MFIS of any referral to medical or other professional societies and State licensing boards in cases involving unethical or unprofessional conduct. They include with the notification to OIG/OI copies of all materials referred to the society or board. Contractors send OIG/OI and the MFIS a follow-up report on significant developments. They notify OIG/OI about possible abuse situations when it appears that a harmful medical practice or a sanctionable practice is occurring or has occurred.

Notice of suspension should also be given to the Medicaid SURs since a significant percent of Medicare beneficiaries are eligible for both Medicare and Medicaid and Medicaid is paying co-payments

### **10.3 – Referral to PROs{tc "10.3 – Referral to PROs" \l 2}**

Contractors should maintain an ongoing dialogue with the PROs. Intermediaries may make referrals to the PRO for review of inpatient claims when outpatient claims reveal a problem provider. It may also be appropriate to refer a provider to the PRO for action by the State licensing agency or medical society. However, if the contractor refers a provider directly to the State licensing agency or medical society, i.e., those referrals which need immediate response

from the State licensing agency, it should also send a copy of the referral to the PRO. Also, contractors notify the PRO of Part A providers and physicians that are suspected of fraud and of referrals to OIG/OI.

Contractors check with OIG/OI before making a referral to a PRO. OIG/OI may need to make the referral to the PRO for the PRO to request approval of contract modifications in accordance with HCFA instructions.

Contractors bring to the attention of the referral entity any activity (over-utilization, mis-utilization, over-charging, etc.) that warrants its involvement. They ask the peer review body to specify in its determination whether or not the items and services being furnished by the subject of the referral are substantially in excess of the needs of the beneficiaries or of a quality that fails to meet professionally recognized standards of health care. The review decision needs to address the specific problems identified in individual cases in terms easily understood by the layman. Contractors do not use general statements concerning the pattern of practice.

## **11 – Administrative Sanctions{tc "11 – Administrative Sanctions"}**

The term "sanctions" represents the full range of administrative remedies and actions available to deal with questionable, improper, or abusive practices of practitioners, providers, and suppliers under the Medicare and Medicaid programs or any State health care programs as defined under §1128(h) of the Act. There are two purposes for these sanctions. First, they are designed to be remedial to ensure that questionable, improper, or abusive practices are dealt with appropriately. Practitioners, providers, and suppliers are encouraged to correct their behavior and operate in accordance with program policies and procedures. Second, the sanctions are designed to protect the programs by ensuring that improper payments are identified and recovered and that future improper payments are not made.

The primary focus of this section is sanctions authorized in §1128 of the Act (exclusions). Other less severe administrative remedies may precede the more punitive sanctions affecting participation in the programs. The corrective actions contractors should initially consider are:

- Provider education and warnings;
- Revocation of assignment privileges;
- Withholding of payments;
- Recovery of overpayments, and
- Referral of situations to State Licensing Boards or Medical/Professional Societies.

The less-severe measures do not apply in the case of §1128 where the exclusion of an entity, other than an individual, is based on a program-related conviction.

### **11.1 – The Contractor’s Role{tc "11.1 – The Contractor’s Role" \l 2}**

The contractor is responsible for:

- Contacting OIG/OI when it determines that an administrative sanction against an abusive provider/supplier is appropriate;
- Providing OIG/OI with appropriate documentation in proposed administrative sanction cases;
- Furnishing any available information to the OIG/OI with respect to providers/suppliers requesting reinstatement;
- Reviewing the Monthly Listing of Sanction Actions to ensure that no payments are made for services rendered by a provider/supplier following the effective date of exclusion;
- Reporting all instances where an excluded provider/supplier submits claims for which payment may not be made after the effective date of the exclusion (see PIM Chapter 3, §11.2.1); and
- Ensuring that no payments are made to provider/suppliers for a salaried individual who is excluded from the program. OIG, as it becomes aware of such employment situations, notifies providers that payment for services furnished to Medicare patients by the individual is prohibited and that any costs (salary, fringe benefits, etc.) submitted to Medicare for services furnished by the individual will not be paid. A copy of this notice is sent to the contractor and to the appropriate RO.

## **11.2 – Authority to Exclude Practitioners, Providers, and Suppliers of Services**

Section 1128 of the Act provides the Secretary of DHHS with the authority to exclude various health care providers, individuals, and businesses from receiving payment for services that would otherwise be payable under Medicare, Medicaid, the Maternal and Child Health Services Block Grant Program, and the Block Grants to States for Social Services Programs. This authority has been delegated to the OIG.

When an exclusion is imposed, no payment is made to anyone for any items or services (other than an emergency item or service provided by an individual who does not routinely provide emergency health care items or services) furnished, ordered, or prescribed by an excluded party under the Medicare, Medicaid, Maternal and Child Health Services Block Grant Program, or Block Grants to States for Social Services Program. In addition, no payment is made to any business or facility, e.g., a hospital, that submits claims for payment of items or services provided, ordered, prescribed, or referred by an excluded party.

OIG also has the authority under §1128(b)(6) of the Act to exclude from coverage items and services furnished by practitioners, providers, or other suppliers of health care services who have engaged in certain forms of program abuse. Where Medicare payment is precluded as a result of exclusion, payment also is not made under any State health care program. Contractors submit to OIG/OI directly all potential §1128(b)(6) sanction cases. Each OIG/OI has a contact person who is responsible for coordinating sanction activities. Contractors direct any questions to that contact person.

Authority under §1156 of the Act is delegated to OIG to exclude practitioners and other persons who have been determined by a PRO to have violated their obligations under §1156 of the Act. To exclude, the violation of obligation under §1156 of the Act must be a substantial violation in a substantial number of cases or a gross and flagrant violation in one or more instances. Payment is not made for items and services furnished by an excluded practitioner or other person. Section 1156 of the Act also contains the authority to impose a monetary penalty in lieu of exclusion. Section 1156 exclusion actions and monetary penalties are submitted by PROs to the OIG/OI.

### **11.2.1 – Basis for Exclusion Under §1128(b)(6) of the Act**

Exclusions under §1128(b)(6) of the Act are effected upon a determination that a provider has:

- Submitted or caused to be submitted claims or requests for payment under Medicare or a State health care program containing charges (or costs) for items or services furnished substantially in excess of its usual charges (or costs); or
- Furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under Medicare or under a State health care program) substantially in excess of the needs of such patients or of a quality that does not meet professionally recognized standards of health care.

For purposes of the exclusion procedures, "furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual or ordered or prescribed by a physician (either as an employee or in his or her own capacity), a provider, or other supplier of services.

### **11.2.2 – Identification of Potential Exclusion Cases**

The fraud unit is to review and evaluate abuse cases to determine if they warrant exclusion action. Examples of abuse cases suitable for exclusion include, but are not limited to:

- Providers who have been the subject of an adverse peer review finding;
- Providers whose claims must be reviewed continually because of repeated instances of overutilization;
- Providers who have been the subject of a previous case which was not accepted for prosecution because of the low dollar value, or who was the subject of a previous case which was settled without exclusion;
- Providers who furnish or cause to be furnished items or services that are substantially in excess of the patient's needs or are of a quality that does not meet professionally recognized standards of health care (whether or not eligible for benefits under Medicare, Medicaid, title V or title XX); and

- Providers who are the subject of prepayment review for an extended period of time (longer than 6 months) who have not corrected their pattern of practice after receiving educational/warning letters.

Also, §1833(a)(1)(D) of the Act provides that payment for clinical diagnostic laboratory tests is made on the basis of the lower of the fee schedule or the amount of charges billed for such tests. Laboratories are subject to exclusion from the Medicare program under §1128(b)(6)(A) of the Act where the charges made to Medicare are substantially in excess of their customary charges to other clients. This is true regardless of the fact that the fee schedule exceeds such customary charges.

Generally, to be considered for exclusion due to abuse, the practices have to consist of a clear pattern that the provider/supplier refuses or fails to remedy in spite of efforts on the part of the contractor, PRO or peer review groups. An exclusion recommendation is implemented only where efforts to get the provider/supplier to change the pattern of practice are unsuccessful. The educational or persuasive efforts are not necessary or desirable when the issues involve life-threatening or harmful care or practice.

If a case involves the furnishing of items or services in excess of the needs of the individual or of a quality that does not meet professionally recognized standards of health care, contractors make every effort to obtain reports confirming the medical determination of their medical review from one or more of the following:

- The PRO for the area served by the provider/supplier;
- State or local licensing or certification authorities;
- Peer review committees;
- State or local professional societies; and
- Other sources deemed appropriate.

## **A – Cases Where Convictions Have Been Obtained**

All cases in which an institutional provider is convicted of a program-related offense are considered for sanction action. These cases are handled by OIG/OI and the Office of Civil Fraud and Administrative Adjudication (OCFAA) Headquarters.

### **11.2.3 – Development of Potential Exclusion Cases**

#### **A – Case Considerations**

When contractors recommend cases to OIG/OI for exclusion, they consider:

- The nature and seriousness of the acts in question;

- Actions taken to persuade the provider/supplier to abstain from further questionable acts;
- The experience gained from monitoring payments to the provider/supplier after corrective action was taken;
- The degree of deterrence that might be brought about by exclusion;
- The effects of exclusion on the delivery of health care services to the community; and
- Any other factors deemed appropriate.

In cases recommended to OIG/OI for exclusion where there has **not** been a conviction, a **pattern** of one of the following must be shown to exist:

- Excessive charges (costs); or
- Excessive services or services of a quality that fail to meet professionally recognized standards.

In both instances, the documentation must include the length of time that the problem existed and the dollars lost by the program. Documentation of excessive services or poor quality of care requires a medical opinion from a qualified physician. All cases involving excessive services or poor quality of care must also contain documentation of prior unsuccessful efforts to correct the problem through the use of less serious administrative remedies.

## **B – Notification to Provider**

If, as a result of development of potential fraud or abuse, a situation is identified that meets one or more of the criteria in the PIM Chapter 3, §11.2.1, contractors consult the OIG/OI sanctions contact person. With approval, they send the provider a written notice containing the following information:

- Identification of the provider;
- The nature of the problem;
- The health care services involved;
- The basis or evidence for the determination that a violation has occurred. In cases concerning medical services, make every effort to include reports and opinions from a PRO or a peer review committee, or a State/local professional society;
- The sanction to be recommended;
- An invitation to discuss the problem with contractor and OIG/OI staff, or to submit written information regarding the problem; and

- A statement that a recommendation for consideration of sanctions will be made to the OIG/OI within 30 days if the problems are not satisfactorily resolved.

If the provider/supplier accepts the invitation to discuss the issues, contractors make a report of the meeting for the record. This does not have to be a professionally transcribed report. Copies of the letter to the provider/supplier and provider response, or the summary of the meeting, must be in the file.

Contractors refer cases that demonstrate a strong fraud potential to OIG/OI for investigation.

They notify OIG/OI of any cases that reach the level where a provider/supplier is notified of a problem in accordance with this section, even if the provider is convinced that there was a legitimate reason for the problem or that the problem has been corrected. Contractors do not refer these cases to OIG/OI unless requested to do so.

Contractors document and refer cases involving harmful care as rapidly as possible. They handle OIG/OI requests for additional information as priority items.

## **C – Additional Information**

Additional information that may be of value in supporting a proposal to exclude includes any adverse impact on beneficiaries, the amount of damages incurred by the programs, and potential program savings.

## **D – Mitigating Circumstances**

Any significant factors that do not support a recommendation for exclusion or that tend to reduce the seriousness of the problem are also considered. One of the primary factors is the impact of the sanction action on the availability of health care services in the community. Contractors bring mitigating circumstances to the attention of OIG/OI when forwarding their sanction recommendation.

### **11.2.4 – Contents of Sanction Recommendation**

Contractors include in the sanction recommendation (to the extent appropriate) the following information:

- Identification of subject including the subject's name, address, date of birth, social security number, and a brief description of the subject's special field of medicine. If the subject is an institution or corporation, include a brief description of the type of services it provides and the names of its officers and directors;
- A brief description of how the violation was discovered;
- A description of the subject's fraudulent or abusive practices and the type of health service(s) involved;

- A case by case written evaluation of the care provided, prepared by the contractor's MR staff which includes the patient's medical records. This evaluation needs to cite what care was provided and why such care was unnecessary and/or of poor quality. (The reviewer may want to consult with someone from their RO OCSQ.) The reviewer should understand that Medicare reimbursement rules are not the basis for a determination that the care was not medically necessary. The reviewer needs to identify the specific date, place, circumstance, and any other relevant information. If possible, the reviewer should review the medical records of the care provided to the patient before and after the care being questioned;

**NOTE:** A minimum of ten cases must be submitted in support of a sanction recommendation under §1128(b)(6)(B). In addition, none of the services being used to support the sanction recommendations can be over 2 years old.

- Documentation supporting the case referral, e.g., records reviewed, copies of any letters or reports of contact showing efforts to educate the provider, if appropriate, profiles of the provider who is being recommended for sanction, and relevant information provided by other program administrative entities;
- Copies of written correspondence and written summaries of the meetings held with the provider regarding the violation;
- Copies of all notices to the party;
- Information on the amount billed and paid to the provider for the 2 years prior to the referral;
- Data on program monies on an assigned/non-assigned basis, for the last 2 years, if available; and
- Any additional information that may be of value in supporting the proposal to exclude or would support the action in the event of a hearing.

**NOTE:** All documents and medical records must be legible.

### **11.2.5 – Notice of Administrative Sanction Action**

When OIG receives the sanction recommendation, it is reviewed by medical and legal staff to determine whether the anticipated sanction action is supportable.

OIG then develops a proposal and sends it to the provider advising it of the recommended sanction period, the basis for the determination that excessive or poor quality care has been provided and its appeal rights. The provider is also furnished with a copy of all the material used to make the determination. This is the material that was previously forwarded to OIG with the initial sanction recommendation.

The provider has 30 days from the date on the proposal letter to submit:

- Documentary evidence and written argument against the proposed action; or
- A written request to present evidence or argument orally to an OIG official.

OIG may extend the 30-day period. All additional information is reviewed by OIG, as well as medical and/or legal personnel, when necessary. In the event the provider requests an in-person review, it is conducted by OIG in Baltimore, MD.

When a final determination is made to exclude a provider, OIG sends a written notice to the provider at least 20 days prior to the effective date of the action. The notice includes:

- The basis for the exclusion;
- The duration of the exclusion and the factors considered in setting the duration;
- The earliest date on which OIG accepts a request for reinstatement, and the requirements and procedures for reinstatement;
- Appeals rights; and
- A statement that, should claims continue to be submitted during the period of sanction for which payments may not be made, the provider/supplier may be subject to a CMP action.

#### **11.2.5.1 – Notification to Other Agencies**

Concurrent with the mailing of the notice to the provider, OIG sends a notice to the contractor, the State agency administering or supervising the administration of each State health care program, the PRO, and the RRB. HCFA is responsible for ensuring proper effectuation of sanction actions.

OIG also notifies the appropriate licensing agency, the public, and all known employers of the sanctioned provider. The MFIS is responsible for circulating this information among its contacts.

#### **Effective Date of Exclusion**

The effective date of exclusion is 20 days from the date of the notice to the provider.

#### **11.2.6 – Denial of Payment to an Excluded Party**

Contractors do not make payment to any excluded provider for items or services furnished, ordered, or prescribed on or after the effective date of exclusion, except in the following cases:

- For inpatient hospital services or post-hospital SNF care provided to an individual admitted to a hospital or SNF before the effective date of the exclusion, make payment, if appropriate, for up to 30 days after that date; and

- For home health services provided under a plan established before the effective date of exclusion, make payment, if appropriate, for 30 days after the date on the notice.

Payment may be made to an excluded provider for emergency items and services furnished, ordered or prescribed (other than an emergency item or service furnished, ordered or prescribed in a hospital emergency room) on or after the effective date of exclusion.

#### **11.2.6.1 – Denial of Payment to Employer of Excluded Physician{tc "11.2.6.1 – Denial of Payment to Employer of Excluded Physician" \l 4}**

If an excluded physician is employed in a hospital setting and submits claims for which payment is prohibited, the Part B carrier surveillance process usually detects and investigates the situation.

However, in some instances an excluded physician may have a salary arrangement with a hospital or clinic or work in group practice and may not directly submit claims for payment. If this situation is detected, carriers:

- Contact the hospital/clinic/group practice and inform them that they are reducing the amount of their payment by the amount of Federal money involved in paying the excluded physician; and
- Develop a CMP or other type of action.

They notify OIG/OI of all situations as described above.

Payment may be made to an excluded physician for emergency items and services furnished, ordered, or prescribed (other than emergency item or service furnished, ordered, or prescribed in a hospital emergency room) on or after the effective date of exclusion.

#### **11.2.6.2 – Denial of Payment to Beneficiaries and Others{tc "11.2.6.2 – Denial of Payment to Beneficiaries and Others" \l 4}**

If claims are submitted after the effective date of the exclusion by a beneficiary for items or services furnished, ordered, or prescribed by an excluded provider, contractors:

- Pay the first claim submitted by the beneficiary and immediately give notice of the exclusion; and
- Do not pay the beneficiary for items or services provided by an excluded party more than 15 days after the date of the notice to the beneficiary or after the effective date of the exclusion, whichever is later. The regulatory time frame is 15 days, however, HCFA allows an additional five days for mailing.

If claims are submitted by a laboratory or DME company, for any items or services ordered by a provider excluded under §1156, or any items or services ordered or prescribed by a physician excluded under §1128, contractors handle the claims as above.

## **A – Notice to Beneficiaries**

To ensure that the notice to the beneficiary indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received your claim for services furnished by \_\_\_\_\_ on \_\_\_\_\_. Effective \_\_\_\_\_, \_\_\_\_\_ was excluded from receiving payment for items and services furnished to Medicare beneficiaries. This notice is to advise you that no payment will be made for any items or services furnished by \_\_\_\_\_ if rendered more than 20 days from the date of this notice."

## **B – Notice to Others**

The Medicare Patient and Program Protection Act of 1987 provides that payment is denied for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156. It also provides that payment cannot be denied until the supplier of the items and services has been notified of the exclusion.

If claims are submitted by a laboratory or a DME company for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156, contractors:

- Pay the first claim submitted by the supplier and immediately give notice of the exclusion; and
- Do not pay the supplier for items or services ordered or prescribed by an excluded provider if such items or services were ordered or prescribed more than 20 days after the date of notice to the supplier, or after the effective date of the exclusion, whichever is later.

To ensure that the notice to the supplier indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received your claim for services ordered or prescribed by \_\_\_\_\_ on \_\_\_\_\_. Effective \_\_\_\_\_, \_\_\_\_\_ was excluded from receiving payment for items or services ordered or prescribed for Medicare beneficiaries. This notice is to advise you that no payment will be made for any items or services ordered or prescribed by \_\_\_\_\_ if ordered or prescribed more than 20 days from the date of this notice."

## **11.3 – Appeals Process{tc "11.3 – Appeals Process" \l 2}**

An excluded provider may try to have the decision reversed or modified, through the appeals process. The Departmental Grants Appeals Board is responsible for processing hearing requests received from sanctioned providers.

## **11.4 – Reinstatements{tc "11.4 – Reinstatements" \l 2}**

A provider may apply for reinstatement at the expiration of the sanction period or any time thereafter. Contractors refer all requests for reinstatement to OIFO. Also, they furnish, as

requested, information regarding the subject requesting reinstatement. OIG notifies the contractor of all reinstatements.

### **11.4.1 – Monthly Notification of Sanction Actions**

A listing containing exclusion and reinstatement/withdrawal actions taken by OIG is distributed to contractors on a monthly basis. A cumulative listing of all current sanctions is issued semi-annually.

Contractors use the information contained in this listing to:

- Determine whether a physician/practitioner/provider or other health care supplier who seeks approval as a provider of services in the Medicare/Medicaid programs is eligible to receive payment; and
- Ensure that sanctioned providers are not being inappropriately paid.

The dates reflected on the monthly listing are the effective dates of the exclusion. Exclusion actions are effective 20 days from the date of the notice. Reinstatements or withdrawals are effective as of the date indicated.

The listing of sanctioned providers shows the names of a number of individuals and entities where the sanction period has expired. These names appear on the list because the individual or entity has not been granted reinstatement. Therefore, the sanction remains in effect until such time as reinstatement is granted.

Upon receipt of this listing, contractors must check their systems to determine whether any physician, practitioner, provider or other health care supplier is being paid for items or services provided subsequent to the date they were excluded from participation in the Medicare program. In the event a situation is identified where inappropriate payment is being made, they notify OIG and take appropriate action to correct the situation. Also, contractors consider the instructions contained in the PIM Chapter 3, §12, with respect to CMPs.

Contractors are responsible for ensuring that no payments are made after the effective date of a sanction except as provided for in regulations at 42 CFR 1001.1901(c) and 489.55.

Contractors check payment systems periodically to determine whether any provider, practitioner, or supplier, who has been excluded since January 1982, is submitting claims for which payment is prohibited. If any such claims are submitted by practitioners, providers or suppliers who have been sanctioned under §§1128, 1862(d), 1156, 1160(b) or 1866(b) of the Act, contractors forward them to OIG/OI.

Also, contractors refer all cases to the RO that involve habitual assignment violators. In cases where there is an occasional violation of assignment by a provider, they notify the provider in writing that continued violation could result in a penalty under the CMPL.

### **12 – Civil Monetary Penalties Law (CMPL)**

The Secretary has the authority to impose CMPs under the provisions of §1128A of the Act. This authority has been delegated to the OIG.

These penalties may be imposed where the Secretary determines that a person presents or causes to be presented a claim for:

- An item or service not provided as claimed;
- An item or service that is false or fraudulent;
- A physician's service provided by a person who was not a licensed physician, whose license had been obtained through misrepresentation, or who improperly represented to a patient that he/she was a certified specialist; or
- An item or service furnished by an excluded person.

Contractors take the following action if it appears that the CMPL provisions might apply:

- Promptly telephone OIG/OI upon discovery of any case that may have CMPL aspects, regardless of whether there is any other pending activity, or the case was closed earlier;
- Before pursuing any sizable or recurring overpayment demands in any case or any significant cost report adjustment, contact OIG/OI to discuss the possibility of CMPL involvement; and
- Similarly, in situations where contractors elect to place a practitioner on prepay review or other edit action because upcoding or other forms of misrepresentation of services may be involved, consult OIG/OI immediately to determine CMPL potential.

Contractors are notified on a case-by-case basis when practitioners, providers or suppliers are excluded from the Medicare program. In addition, contractors will receive a monthly report of sanctioned individuals or entities. (See PIM Chapter 3, §11.1.)

Contractors are responsible for ensuring that no payments are made after the effective date of a sanction except as provided for in regulations at 42 CFR 1001.1901(c) and 489.55.

They check payment systems periodically to determine whether any provider, practitioner, or supplier, who has been excluded since January 1982, is submitting claims for which payment is prohibited. If any such claims are submitted by practitioners, providers or suppliers who have been sanctioned under §§1128, 1862(d), 1156, 1160(b) or 1866(b) of the Act, contractors forward them to OIG/OI.

### **13 – Monitor Compliance{tc "13 – Monitor Compliance"}**

Contractors follow-up on all incidences of documented false claims to ensure that the problem has not recurred and no longer exists. They send a letter to the provider indicating that they are monitoring their actions.

## **13.1 – Resumption of Payment to A Provider - Continued Surveillance After Detection of Fraud** {tc "13.1 – Resumption of Payment to A Provider - Continued Surveillance After Detection of Fraud " \l 2}

After completion of the investigation and appropriate legal action, all determined overpayments are recouped by either direct refund or offset against payments being held in suspense. Once recoupment is completed, contractors release any suspended monies which are not needed to offset determined overpayments and, if applicable, penalties.

Contractors monitor future claims and related actions of the provider for at least 6 months, to assure the propriety of future payments. In addition to internal screening of the claims, if previous experience or future billings warrant, they periodically interview a sampling of the provider's patients to verify that billed services were actually furnished.

If, at the end of a 6-month period, there is no indication of a continuing aberrant pattern, contractors discontinue the monitoring.

# Medicare Program Integrity Manual

## Chapter 4 – Examples of Fraudulent Activities

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- 1 – Discounts, Rebates, and Other Reductions in Price
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  - 1.4 – Risk-Based Provider Payment: Necessary Factors for Protected Discounts
- 2 – Hospital Incentives
- 3 – Breaches of Assignment Agreement by Physician or Other Supplier
- 4 – Participation Agreement and Limiting Charge Violations

## **1 – Discounts, Rebates, and Other Reductions in Price**

When a contractor learns of a questionable discount program, it contacts OIG/OI to determine how to proceed. OIG/OI may ask for immediate referral of the matter for investigation.

### **1.1 – Anti-Kickback Statute Implications**

The Medicare and Medicaid anti-kickback statute provides as follows:

"Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or a State health care program, or in return for purchasing, leasing, or ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under Medicare, Medicaid or a State health program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both. 42 U.S.C. 1320a-7b(b), §1128B(b) of the Act."

Discounts, rebates, or other reductions in price may violate the anti-kickback statute because such arrangements induce the purchase of items or services payable by Medicare or Medicaid. However, some arrangements are clearly permissible if they fall within a safe harbor. One safe harbor protects certain discounting practices. For purposes of this safe harbor, a "discount" is the reduction in the amount a seller charges a buyer for a good or service based on an arms-length transaction. In addition, to be protected under the discount safe harbor, the discount must apply to the original item or service which is purchased or furnished i.e., a discount cannot be applied to the purchase of a different good or service than the one on which the discount was earned. A "rebate" is defined as a discount that is not given at the time of sale. A buyer is the individual or entity responsible for submitting a claim for the item or service which is payable by the Medicare or Medicaid programs. A seller is the individual or entity that offers the discount.

### **1.2 – Cost-Based Payment (Intermediary Processing of Part A Claims): Necessary Factors for Protected Discounts**

For a discount to be protected, certain factors must exist. These factors assure that the benefit of the discount or rebate will be reported and passed on to the programs. If the buyer is a Part A provider, it must fully and accurately report the discount in its cost report. The buyer may note the submitted charge for the item or service on the cost report as a "net discount." In addition, the discount must be based on purchases of goods or services bought within the same fiscal year. However, the buyer may claim the benefit of a discount in the fiscal year in which the discount is earned or in the following year. The buyer is obligated, upon request by DHHS or a State agency, to provide information given by the seller relating to the discount.

The following types of discounts may be protected if they comply with all the applicable standards in the discount safe harbor:

- Rebate check;
- Credit or coupon directly redeemable from the seller; and
- Volume discount or rebate.

The following types of discounts are not protected:

- Cash payment;
- Furnishing one good or service free of charge or at a reduced charge in exchange for any agreement to buy a different good or service;
- Reduction in price applicable to one payer but not to Medicare or a State health care program; and
- Routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary.

**NOTE:** There is a separate safe harbor for routine waiver of co-payments for inpatient hospital services.

### **1.3 – Charge-Based Payment (Intermediary Processing of Part B Claims): Necessary Factors for Protected Discounts**

For a discount program to be protected for Part B billing, certain factors must exist. These factors assure that the benefit of the discount or other reduction in price is reported and passed on to the Medicare or Medicaid programs. A rebate rendered after the time of sale is not protected under any circumstances. The discount must be made at the time of sale of the good or service. In other words, rebates are not permitted for items or services if payable on the basis of charges. The discount must be offered for the same item or service that is being purchased or furnished. The discount must be clearly and accurately reported on the claim form.

Credit or coupon discounts directly redeemable from the seller may be protected if they comply with all the applicable standards in the discount safe harbor.

The following types of discounts are not protected:

- Rebates offered to beneficiaries;
- Cash payment;
- Furnishing an item or service free of charge or at a reduced charge in exchange for any agreement to buy a different item or service;

- Reduction in price applicable to one payer but not to Medicare or a State health care program; and
- Routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary.

**NOTE:** There is a separate safe harbor for routine waiver of co-payments for inpatient hospital services.

## **1.4 – Risk-Based Provider Payment: Necessary Factors for Protected Discounts**

If the buyer is a health maintenance organization or a competitive medical plan acting in accordance with a risk contract or under another State health care program, it need not report the discount, except as otherwise required under the risk contract.

## **2 – Hospital Incentives**

As many hospitals have become more aggressive in their attempts to recruit and retain physicians and increase patient referrals, physician incentives (sometimes referred to as "practice enhancements") are becoming increasingly common. Some physicians actively solicit such incentives. These incentives may result in reductions in the physician's professional expenses or an increase in their revenues. In exchange, the physician is aware that he or she is often expected to refer the majority, if not all, of his or her patients to the hospital providing the incentives.

OIG has become aware of a variety of hospital incentive programs used to compensate physicians (directly or indirectly) for referring patients to the hospital. These arrangements are prohibited by the anti-kickback statute because they can constitute remuneration offered to induce, or in return for, the referral of business paid for by Medicare or Medicaid.

These incentive programs can interfere with the physician's judgement of what is the most appropriate care for a patient. They can inflate costs to the Medicare program by causing physicians to inappropriately overuse the services of a particular hospital. The incentives may result in the delivery of inappropriate care to Medicare beneficiaries and Medicaid recipients by inducing the physician to refer patients to the hospital providing financial incentives rather than to another hospital (or non-acute care facility) offering the best or most appropriate care for that patient. Indicators of potentially unlawful activity include:

- Payment of any sort by the hospital each time a physician refers a patient to the hospital;
- The use of free or significantly discounted office space or equipment (in facilities usually located close to the hospital);
- Provision of free or significantly discounted billing, nursing, or other staff services;

- Free training for a physician's office staff in areas such as management techniques, CPT coding, and laboratory techniques;
- Guarantees which provide that, if the physician's income fails to reach a predetermined level, the hospital supplements the remainder up to a certain amount;
- Low-interest or interest-free loans, or loans that may be "forgiven" if a physician refers patients (or some number of patients) to the hospital;
- Payment of the cost of a physician's travel and expenses for conferences;
- Payment for a physician's continuing education courses;
- Coverage on hospital's group health insurance plans at an inappropriately low cost to the physician; and
- Payment for services (which may include consultations at the hospital) that require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of services furnished.

When contractors learn of a questionable hospital incentive program, the matter must be referred to OIG/OI.

Contractors must never give out in writing or orally an opinion on whether or not a particular business arrangement is in violation of the kickback law. This law is within the exclusive jurisdiction of the DOJ.

### **3 – Breaches of Assignment Agreement by Physician or Other Supplier{tc "3 – Breaches of Assignment Agreement by Physician or Other Supplier" }**

#### **A – Criminal Penalty**

The law provides that any person who accepts an assignment of benefits under Medicare and who "knowingly, willfully, and repeatedly" violates the assignment agreement shall be guilty of a misdemeanor and subject to a fine of not more than \$2,000 or imprisonment of not more than 6 months or both.

#### **B – Administrative Sanction**

HCFA may revoke the right of a physician (or other supplier, or the qualified reassignee of a physician or other supplier), to receive assigned benefits if the physician (or other party) who has been notified of the impropriety of the practice:

- Collects or attempts to collect more than the Medicare allowed charge as determined for covered services after accepting assignment of benefits for such items or services; or
- Fails to stop collection efforts already begun or to refund monies incorrectly collected.

## **C – CMPs**

The statute provides for CMPs of up to \$2,000 per item or service claimed against any person who violates an assignment agreement.

## **D – Action by Contractor on Receipt of Initial Complaint**

Upon receipt of the initial assignment agreement violation complaint or complaints against a physician, contractors must develop the facts to ascertain whether the allegation is valid, regardless if the complaint is referred from an SSA FO, an OIFO, beneficiary, or the RO.

If a violation has occurred, contractors contact the physician in person, by phone, or by mail to explain the obligations assumed in accepting assignment and to obtain his/her assurance that improperly collected monies are being refunded and that further billings in violation of the assignment agreement will cease. Contractors inform the physician of the possible criminal penalty discussed in subsection A, the possible administrative sanction, i.e., revocation of the assignment privilege discussed in subsection B, and the possible CMPs discussed in subsection C. The dates and other particulars of the contact with the physician must be recorded.

Contractors must supplement any personal or phone contact with a letter to the physician explaining his/her assignment obligations and the possible sanctions. The contractor closes the case with that letter if the physician response is satisfactory. A satisfactory response includes the following actions:

- The physician acknowledges the obligations of the assignment agreement and agrees:
  - To make any necessary refund;
  - To credit the refund due against other amounts owed; and
  - To stop further incorrect billing and refunds or credits any amount due the complainant as verified by the contractor.

If the physician response is unsatisfactory, contractors refer the case to the fraud unit for further action. The action taken by the fraud unit depends on the circumstances. If the physician persists in billing the patient for the charges that gave rise to the complaint or fails to make any refund due, the fraud unit should complete the SSA-2808 (see PIM Chapter 4 §3.H) and refer the case to the RO for initiation of steps to revoke the physician's assignment privilege. However, the RO may find it desirable to give the physician further written warning before undertaking such action.

If the physician has violated his/her assignment agreement in connection with additional claims after having been warned, see PIM Chapter 4, §3 subsection E.

## **E – Action by Fraud Unit When Violations Occur After Warning**

Upon receipt of a new assignment violation complaint(s) after the physician has been given the warning described in subsection D, contractors develop the facts and refer the case to the RO with a report, regardless if the complaint is referred from an SSA FO, OIFO, or RO. Contractors

may wish to substitute an oral report to the RO in situations where the contractors have resolved the repeat violation. The RO considers whether to initiate action to revoke the physician's assignment privilege.

## **F – Procedure for Revoking Assignment Privilege**

The RO may revoke assignment privileges when prosecution is inappropriate or not feasible. The RO notifies the physician of the proposed revocation of his right to receive assigned benefits and gives him/her 15 days to submit a statement, including any pertinent evidence, explaining why his/her right to payment should not be revoked. After the statement is received, or the 15-day period expires without the filing of the statement, the RO determines whether to revoke the physician's right to receive payment. If the determination is to revoke the physician's right to receive payment, the RO notifies the contractor to suspend payment on all assigned claims received after the effective date of the revocation. The RO also notifies the physician of the revocation, and of his/her right to request a formal hearing on the revocation within 60 days. (The RO may extend the period for requesting a hearing.)

If the physician requests a formal hearing (to be conducted by a member of the Hearing Staff of the Office of Budget and Administration, HCFA) and the hearing officer reverses the revocation determination, the RO instructs the contractor to pay the physician's claims.

If the hearing officer upholds the revocation determination, or if no request for a hearing is filed during the period allowed, the RO instructs the contractor to make any payments otherwise due the physician to the beneficiary who received the services or to another person or organization authorized under the law and regulations to receive the payments. (See MCM §7050ff for payment to a representative payee or legal representative.) If the beneficiary is deceased, contractors must make payment in accordance with the requirements of MCM §§7200ff. to the person who paid the claim, to the legal representative of the beneficiary's estate, or to his/her survivors. (Contractors do not make payment to the physician.) The revocation remains in effect until the RO finds that the reason for the revocation has been removed and there is reasonable assurance that it will not recur. The RO's decision to continue the revocation is not appealable.

When the right of a person or organization to receive assigned payment is revoked, the revocation applies to any benefits payable to that person or organization throughout the country. The RO is responsible for notifying those contractors who are likely to receive claims.

See MCM §3060.9B for the effect of revocation of a physician's or other person's assignment privileges on the right of a hospital or other entity to accept assignment for his/her services. This section also contains information concerning the effect of revocation of a hospital's or other entity's assignment privileges on the right of a physician or other person for whom it has been billing, to bill for his/her own services.

## **G – Other Considerations**

Because of the Government's responsibility to prosecute persons who repeatedly violate the assignment agreement, effective monitoring of such offenses is very important. The factors involved in each case may vary, and contractors need to discuss with the RO, OIFO as appropriate, any situation where the contractors believe that legal or administrative action is necessary. In addition, contractors are to utilize the specific control measures and referral

procedures in accordance with RO/OIG-OI direction. The RO may review the contractors' actions to assure that assignment violations are being properly tracked and reported.

Contractors must notify physicians and other suppliers of the implications of §1842(b)(3)(ii) of the Act since the penalties for violations of the assignment agreement are significant. Contractors use the language contained in these letters, or similar language, when contacting providers regarding assignment violation. Contractors must ensure that all physicians are made aware of the penalties that can be imposed. This deters assignment violations and works against a defense by physicians that they had no knowledge of these laws.

## **H -- Form for Reporting Assignment Agreement Violations**

Form SSA-2808, Notice of Reported Assignment Agreement Violation, is specifically designed for SSA FOs and contractors to use in handling assignment agreement violations. SSA FOs use this form for referral and control of complaints. Contractors use it to report action on complaints.

SSA FOs are responsible for completing sections one and two completely and clearly. They are to forward the original plus one copy and a second copy is to be sent to the servicing RO. A third copy is kept by the SSA FO for control and follow-up purposes. A fourth copy is sent to the appropriate RO for informational purposes.

In the event that there is an undue delay (in excess of 45 days) by the contractor in processing complaints, the SSA FO sends periodic interim reports (monthly) to beneficiaries/complainants informing them that as soon as action is taken notification is sent to them. This action precludes excessive inquiries to the contractor. If an SSA FO wishes to determine the status of the complaint, it contacts the RO.

Contractors complete §3 of the SSA-2808 and forward a copy to the RO when appropriate action is completed. The RO notifies the originating SSA FO of the action taken.

## **4 – Participation Agreement and Limiting Charge Violations{tc "4 – Participation Agreement and Limiting Charge Violations"}**

Section 2306 of the Deficit Reduction Act of 1984 established a physician/supplier participation program. The Omnibus Budget Reconciliation Act (OBRA) of 1989 established a limitation on actual charges by nonparticipating physicians. (See §1848(g) of the Act.) Participating physicians/suppliers who violate their participation agreements, and nonparticipating physicians who knowingly, willfully, and repeatedly increase their charges to Medicare beneficiaries beyond the limits, are liable for action in the form of CMPs, assessments, and exclusion from the Medicare program for up to 5 years, or both. Criminal penalties also apply to serious violations of the participation agreement provisions.

For further discussion of the participation agreement/limiting charge provisions, see MCM §§5000ff. and 7555, respectively.

# Medicare Program Integrity Manual

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#### 7.7 - DMERC Tracking

## **1 – Home Use of DME{tc "1 – Home Use of DME"}**

Medicare law limits Part B payment for DME to items/supplies used (delivered) in the patient's home. For claims that show a nursing home or hospital address as the beneficiary's residence, or if the place of service code indicates that the beneficiary is an inpatient of a hospital or nursing home, DMERCs develop for the date of admission and determine whether payment is possible. (See PIM Chapter 5, §4.) If a hospital is a participating hospital, an emergency hospital, or a hospital which meets the requirements of §1861(e)(1) of the Act, it **does not** qualify as the patient's home.

The following screening guides apply when the individual is in an SNF:

- Where an institution is classified as a participating SNF, an §1819 (a) (1) institution, or where a SNF has a part classified as participating and a part classified as meeting §1819 (a) (1) of the Act, it cannot be considered the individual's home;
- If an institution has a part which is participating or a part which meets §1819 (a) (1), and a remaining part which does not meet §1819 (a) (1), identify the part in which the patient was physically located during the use period. The institution may be considered the individual's home only if he/she was in the part which does not meet §1819 (a) (1). See MCM §2312.1 if an item of equipment is furnished or used outside the U.S.; or,
- If a DME rental start date coincides with the patient's discharge date from an institution not classified as a "home", DMERCs pay for medically necessary DME.

These rules apply only to DME claims. Orthotic and prosthetic devices are not subject to the "home use" requirement for coverage and payment purposes.

### **1.1 – Physician Orders{tc "1.1 – Physician Orders" \l 2}**

The supplier for all Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) is required to keep on file a physician prescription (order). The treating physician must sign and date the order. A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary.

#### **1.1.1 – Dispensing Orders{tc "1.1.1 – Dispensing Orders" \l 3}**

Except for items requiring a written order prior to delivery, the dispensing order may be a written, fax, or verbal order.

The dispensing order must include:

- A description of the item;
- The beneficiary's name;
- The name of the physician; and
- The date of the order.

The dispensing order does not need to be as detailed as the written order which is required before submitting a claim. The supplier must maintain written documentation of the dispensing order and this documentation must be available to the DMERC on request.

A written order prior to delivery is required for pressure reducing pads, mattress overlays, mattresses, and beds (A4640, E0176-E0189, E0192-E0199, E0277, E0371-E0373) seat lift mechanisms (E0627-E0629), TENS units (E0720-E0730), and power operated vehicles (E1230). For these items, the supplier must have received a detailed written order that has been both signed and dated by the treating physician before dispensing the item.

If the supplier does not have an order from the treating physician before dispensing an item, the item is noncovered, and the supplier must not submit a claim for the item to the DMERC.

### **1.1.2 – Detailed Written Orders**

A supplier must have a verbal, faxed, or original order in their records before they provide any item of durable medical equipment, prosthetics, orthotics and supplies to a beneficiary.

If the order is for an item that has been dispensed before the date that the detailed written order is signed (e.g., a written confirmation of a verbal order), the order must clearly specify the start date.

For items that are dispensed based on a verbal order, the written order must clearly specify the start date of the order. If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need.

The supplier must retain the detailed written order and it must be available to the DMERC on request. The detailed written order is in addition to the dispensing order.

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. If the order is for a rented item or if the coverage criteria in a policy specify length of need, the order must include the length of need. If the order is for accessories or supplies that will be provided on a periodic basis, the order must include appropriate information on the quantity used, frequency of change or use, and length of need. (For example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for 1 month or until the ulcer heals.) If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable). The detailed description of the item may be completed by someone other than the physician. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement.

A supplier must have a faxed or original signed order and a faxed or original CMN (when applicable) in their records before they can submit a claim for payment to Medicare.

If the supplier does not have a faxed or original, signed order that has been both signed and dated by the treating physician, the item is noncovered, and the supplier must not submit a claim for

the item to the DMERC. The supplier may not submit a claim based only on a fax order or verbal order.

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is **NOT** in itself considered to be part of the order although it may be put on the same document as the order.

### **1.1.3 – Requirement of New Orders**

A new order is required in the following situations:

- There is a change in the order for the accessory, supply, drug, etc.;
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy;
- When an item is replaced; and
- When there is a change in the supplier.
- In cases where two or more suppliers merge, the resultant supplier should make all reasonable attempts to secure copies of all active CMNs from the supplier(s) purchased. This document should be kept on file by the resultant supplier for future presentation to the DMERC.

### **1.1.4 – CMN as the Written Order**

For items that require a CMN, and for accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the detailed written order **IF** the narrative description in Section C is sufficiently detailed (as described above).

A supplier must have a faxed or original signed order and a faxed or original CMN (when applicable) in their records before they can submit a claim for payment to Medicare.

### **A - Cover Letters for CMNs**

Cover letters can be used by a supplier as a method of communication between the supplier and the physician. It is not HCFA's intent to restrict necessary communication between the supplier and the physician. HCFA does not require nor regulate the cover letter. The DMERCs should not take adverse action against suppliers that solely involve cover letters.

The DMERC should regularly publish an article in their bulletins asking suppliers to remind physicians of their responsibility in completing and signing the CMN. It is the physician's responsibility to determine both the medical need for, and the utilization of, all health care services. The physician should ensure that information relating to the beneficiary's condition is correct. The DMERC should encourage suppliers to include language in their cover letters to remind physicians of their responsibilities.

## **B – Completing a CMN**

The “Initial Date” found in Section A of the CMN, should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the “Initial Date” would be the date of the order.

The “Signature Date” is the date the physician signed and dated Section D of the CMN. This date might not be the same as the “Initial Date”, since the “Signature Date” must indicate when the physician signed Section D of the CMN.

The “Delivery Date/Date of Service” on the claim must not precede the “Initial Date” on the CMN or start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the “Initial Date” of the CMN or 3 months from the start date of the order.

The DMERCs have the authority to request to verify the information on a CMN at any time. If the information contained either in the supplier’s records or in the patient’s medical record maintained by the ordering physician fails to substantiate the CMN, or if it appears that the CMN has been altered, the DMERCs should consider the service not reasonable and necessary and initiate the appropriate administrative actions.

In the event of a post pay audit, the supplier must be able to produce the CMN and, if requested by the DMERC, produce information to substantiate the information on the CMN. If this information cannot be produced by the supplier, the DMERCs should consider the service not reasonable and necessary, and initiate a denial or an overpayment action.

If there is a change made to Section B of the CMN after the physician has completed Section B and signed Section D of the CMN, the physician must line through the correction, initial and date the correction; or the supplier may choose to have the physician complete a new CMN.

If changes are made to Section A or C after the physician has signed the CMN, the supplier must have the physician acknowledge the change by placing their initial on the area that has changed.

## **C – DMERCs’ Authority to Assess an Overpayment and/or CMP When Invalid CMNs Are Identified**

Section 1862(a)(1) of the Act prohibits Medicare payment for services that are not reasonable and necessary. Section 1833(e) of the Act requires that Medicare be furnished by providers and suppliers “such information as may be necessary in order to determine the amount due....” These sections provide support that a failure to have a valid CMN on file or to submit a valid CMN to the DMERC makes the underlying claim improper because Medicare does not have sufficient information to determine whether the claim is reasonable and necessary. A valid CMN is one in which the treating physician has attested to and signed supporting the medial need for the item, and the appropriate individuals have completed the medical portion of the CMN. When the DMERCs identify a claim for which a CMN is not valid, they may deny the claim and/or initiate overpayment action.

If a DMERC identifies a supplier that has a pattern of improperly completing the CMN, the DMERC may choose to develop a potential CMP case against the upplier. The authority for

such action is found in §1834(j)(2)(A)(iii) of the Act which states that “any supplier of medical equipment and supplies who knowingly and willfully distributes a CMN in violation of clause (I) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed \$1,000 for each such certificate of medical necessity so distributed.” The provisions of §1128A of the Act (other than subsections (a) and (b) shall apply to CMPs penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under §1128(A)(a) of the Act.

### **1.1.5 – Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders**

A nurse practitioner or clinical nurse specialist may give the dispensing order and sign the detailed written order in the following situations:

- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing independently of a physician;
- They bill Medicare for other covered services using their own provider number; and
- They are permitted to do all of the above in the state in which the services are rendered.

A nurse practitioner or clinical nurse specialist may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders.

## **2 – Documentation in the Patient’s Medical Record**

For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN, it is recommended that a copy of the completed CMN be kept in the patient’s record. However, neither a physician’s order nor a CMN nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

The patient’s medical record is not limited to the physician’s office records. It may include hospital, nursing home, or HHA records and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DMERC. However, the DMERC may request this information in selected cases. If the DMERC does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

## **2.1 – Supplier Documentation**

Before submitting a claim to the DMERC, the supplier must have on file a dispensing order, the detailed written order, the CMN (if applicable), information from the treating physician concerning the patient's diagnosis (if an ICD-9-CM code is required on the claim), and any information required for the use of specific modifiers or attestation statements as defined in certain DMERC policies. The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item has been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained.

Documentation must be maintained in the supplier's files for seven (7) years,

Suppliers are required to maintain proof of delivery documentation in their files. The proof of delivery requirements are outlined below according to the method of delivery. The three methods of delivery are:

- Supplier delivering directly to the beneficiary or authorized representative;
- Supplier utilizing a delivery/shipping service to deliver items; and
- Delivery of items to a nursing facility on behalf of the beneficiary.

Proof of delivery documentation must be available to the DMERC on request. All services which do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for imposition of CMPs or Administrative Sanctions.

### **2.1.1 – Delivery Method 1 - Supplier Delivers Items Directly to the Beneficiary or Authorized Representative**

A delivery slip is required in order to verify that the DMEPOS item was received. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or authorized representative. An acceptable delivery slip must include the patient's name, the quantity, and a detailed description of the items being delivered, brand name, and serial number.

The date of service on the claim must be the date that the beneficiary or authorized representative received the DMEPOS item.

### **2.1.2 – Delivery Method 2 - Supplier Utilizes a Delivery/Shipping Service{tc "2.1.2 – Delivery Method 2 - Supplier Utilizes a Delivery/Shipping Service" \l 3}**

If a supplier utilizes a delivery/shipping service, acceptable proof of delivery would include the delivery service's tracking slip **and** a supplier's shipping invoice. The supplier's shipping invoice must include the patient's name, the quantity and detailed description of the item(s) being delivered, brand name, serial number, and the delivery service's package identification number associated with the patient's package(s). The delivery service's tracking slip must reference each patient's package(s), the delivery address, and the corresponding package identification number given by the delivery service. Without a delivery service's tracking log which identifies each individual package with a unique identification number and the delivery address, the items will be denied and an overpayment will be requested. In a situation in which the patient denies receipt of an item, the items will be denied and an overpayment will be requested unless the supplier maintains a detailed shipping invoice and the delivery service's tracking log.

For mail order DMEPOS items, the date of service on the claim must be the shipping date.

### **2.1.3 – Delivery Method 3 - Delivery of Items to a Nursing Facility on Behalf of the Beneficiary{tc "2.1.3 – Delivery Method 3 - Delivery of Items to a Nursing Facility on Behalf of the Beneficiary" \l 3}**

Proof of delivery must be maintained in the supplier's records as described for Delivery Methods 1 and 2. For those patients that are residents of a nursing facility, suppliers should work with the nursing facility staff to implement an inventory control to ensure the following:

- Receipt of the supplies at the nursing facility;
- Supplies are identified and retained for use only by the specific patient for which the supplies/items are intended;
- Supplies are utilized by the patient for which they are issued; and
- Suppliers obtain copies of the necessary documentation from the nursing facility to document proof of delivery.

The medical records in the nursing home must document the use of all supplies/items billed to Medicare. The documentation may be in the nurse's notes or a special treatment record or form.

The date of service on the claim must be the date that the DMEPOS item(s) was received by the nursing facility if it was delivered by the supplier or the shipping date if the supplier utilized a delivery/shipping service.

An exception to the preceding statements concerning the date of service on the claim occurs when items are provided in anticipation of discharge from a hospital or nursing facility. If a DMEPOS item is delivered to a patient in a hospital up to two days prior to discharge to home and it is for the benefit of the patient for purposes of fitting or training of the patient on its use,

the supplier should bill the date of service on the claim as the date of discharge to home and should use POS=12. The following further requirements/exceptions apply to this general statement. The item must be for subsequent use in the patient's home and no billing may be made for the item for days used prior to the date of the patient's discharge to home. There must be no billing for drugs or other supplies used with DME or a prosthetic device prior to discharge. There must be no billing for surgical dressings, urological supplies, or ostomy supplies that are applied in the hospital, including items worn home by the patient. Suppliers are responsible for any necessary delivery of DMEPOS items and cannot bill the beneficiary or Medicare program for delivery from the facility to the patient's home. Should a supplier enter into an agreement with a facility to substitute an item for DMEPOS required by statute to be provided by the facility, such practice would be considered fraudulent.

The preceding statements also apply to DME which is delivered to a patient in a skilled nursing facility (POS=31) or nursing facility providing skilled services (POS=32).

### **3 – Evidence of Medical Necessity{tc "3 – Evidence of Medical Necessity"}**

If replacement supplies are needed for the therapeutic use of purchased DMEPOS, the treating physician must specify on the prescription, or on the CMN, the type of supplies needed and the frequency with which they must be replaced, used, or consumed. DMERCs evaluate supply utilization information as part of the medical necessity determination for DMEPOS. They do not accept "PRN" or "as needed" utilization estimates for supply replacement, use, or consumption.

Absent a State law to the contrary **or** a supply utilization problem, the prescription or physician's certification submitted for the DMEPOS may also serve as medical evidence for supply replacement claims. However, when a prescription for DMEPOS is renewed or revised, supply utilization information must be specified or updated by the physician on the CMN. DMERCs assess the continuing medical necessity.

DMERCs must establish procedures for monitoring the utilization of replacement supplies. DMERCs must inform suppliers of the need to submit updated medical information if the patient's condition materially changes the equipment, device, or supply utilization requirements. Absent such notification, DMERCs do not allow claims for unexplained increases in supply utilization above the usage level they previously determined as medically necessary. Suppliers must provide this information with the claim where indicated in published policy or to make it available to the DMERC on request.

If necessary or appropriate for a medical necessity determination, the DMERC must ask the supplier to obtain documentation from the treating physician, establishing the severity of the patient's condition and the immediate and long term need for the equipment and the therapeutic benefits the patient is expected to realize from its use. A claim of therapeutic effectiveness or benefit based on speculation or theory alone cannot be accepted. When restoration of function is cited as a reason for use of DMEPOS, the exact nature of the deformity or medical problem should be clear from the medical evidence submitted. Also, the manner in which the equipment or device will restore or improve the bodily function should be explained by the treating physician.

If the DMERC is unsuccessful in obtaining medical information from the supplier for non-assigned claims, it gives the beneficiary the opportunity to obtain the desired information from

the supplier. If, after obtaining the requested information, a question of medical necessity remains, the DMERC medical staff must resolve the issue.

### **3.1 – Period of Medical Necessity for Home Dialysis Equipment**

The period of medical necessity for **home dialysis equipment** must be specified, e.g., "at least x months." Situations may occur causing temporary non-use of equipment:

- Beneficiary requires in-facility treatment for re-stabilization or as a result of some acute condition. The beneficiary is expected to return to home dialysis.;
- Beneficiary is temporarily without a suitable home dialysis assistant.;
- Beneficiary is away from home but expects to return.; or
- Beneficiary is a transplant candidate and is taken off home dialysis preparatory to transplant. (If the transplant cannot occur, or if the transplant is not successful, the patient will very likely resume home dialysis and an evaluation can be made whether it will be within the immediate or foreseeable future.)

Under such circumstances, DMERCs determine that medical necessity exists and pay for a period of up to 3 months after the month home dialysis equipment was last used. This does not eliminate the necessity for periodic reevaluation of medical necessity. It provides a tolerance to avoid frequent reevaluation in renal dialysis situations and provides for continuity of payments where economically advantageous.

### **3.2 – Safeguards in Making Monthly Payments**

DMERCs must establish appropriate safeguards to assure that payments are not made beyond the last month of medical necessity. They must develop appropriate safeguards to identify and investigate the following:

- Multiple claims for rental of the same or similar equipment from the same supplier within the same rental month (e.g., rental claims with different start dates but within the same rental period);
- Contraindicated items of rented or purchased equipment;
- Incompatible claims information (e.g., liquid oxygen contents billed for a purchased gas delivery system);
- Medical equipment rentals or purchases after a beneficiary's death;
- Rental start dates on or after the purchase of the same or comparable equipment (absent evidence that the beneficiary has disposed of purchased equipment);

- Rental claims for the same or similar equipment from different suppliers for the same or overlapping rental months; and
- Equipment rental start dates within periods of confinement in an institution that cannot be considered a patient's home.

DMERCs must resolve these situations on a prepayment basis. Development, if necessary, may be via written or telephone contact per MCM §3311, subject to any other documentation or development guidelines specified in MCM §§4105ff.

To the extent possible, DMERCs give beneficiaries and supplier-assignees advance notice of the date and reason that payments are scheduled to stop. (See MCM §§7012ff. for EOMB language.)

### **3.2.1 – Guidance on Safeguards in Making Monthly Payments**

It is appropriate to develop safeguards against improper payment of claims. This section provides DMERCs with additional guidance in creating and applying these safeguards to DME claims.

#### **3.2.1.1 – Pick-up Slips**

MCM §4105.2(B) specifically forbids payments for multiple claims for rental of the same or similar equipment from either the same or a different supplier during the same rental month.

For purposes of this section, a pick-up slip is written confirmation, provided by a supplier, that the supplier has removed an item of DME from the beneficiary's home.

When making determinations, DMERCs must ascertain not only whether equipment is present in the home, but must determine which equipment is actually being used by the patient. Therefore, it is inappropriate to determine, solely based on lack of a pick up slip, that a piece of equipment may still be in use. Likewise, it is inappropriate for DMERCs to deny claims solely based on lack of a pick up slip. DMERCs should develop these claims to determine which piece of equipment is medically necessary.

## **4 – Incurred Expenses for DME and Orthotic and Prosthetic Devices{tc "4 – Incurred Expenses for DME and Orthotic and Prosthetic Devices"}**

The first month's expense for rental is incurred on the date of delivery of the equipment. Expenses for subsequent months are incurred on the same date of the month. Where equipment is purchased, benefits are payable on the same basis. Suppliers may submit claims as of the date expenses are incurred. If the date of delivery is not specified on the claim, reviewers assume, in the absence of evidence to the contrary, that the date of purchase or rental was the date of delivery.

Generally, for all DMEPOS, the supplier's date of service (DOS) is the date of delivery to a beneficiary's home. For DMEPOS provided to a beneficiary immediately following a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the date of final discharge to the beneficiary's home. For mail order DMEPOS provided immediately

subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the latter of the actual delivery date or the date of the discharge. Under no circumstances can the DOS be earlier than the date of delivery.

No payment may be made for rental for any month throughout which the patient is in an institution that does not qualify as his or her home (see MCM §2100.3) or is outside the U.S. (See MCM §2312.) If the patient is at home as of the first day of a rental month and, for part of the same rental month, is in an institution which cannot qualify as his or her home, or is outside the U.S., payment may be made for the entire rental month. Similarly, if an item of **rental** equipment is returned to the supplier before the end of a payment month because the beneficiary died in that rental month or because the equipment became unnecessary in that month, payment may be made for the entire rental month. However, if the supplier charges for only part of a month, or the DMERC is aware that the supplier customarily follows such a practice, it pays on a prorated basis. If the individual is outside the U.S. for more than 30 days and returns to the U.S. (before resuming payments), it determines medical necessity as in an initial case.

Note that in the case of purchased equipment, MCM §2312 requires that the beneficiary must have been in the United States when the item was delivered, and MCM §1050 requires that the individual must have had Supplementary Medical Insurance (SMI) coverage at the time the item was delivered. Therefore, where a purchased item of equipment was delivered to an individual outside the United States or before his/her coverage period began (i.e., the effective date of his/her enrollment), the entire expense of the item is excluded from coverage whether it was paid for in its entirety at purchase or on a deferred or installment basis. Payment cannot be made in such cases even though the individual uses the item inside the United States or after his/her coverage begins.

Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied.

## **5 – Patient Equipment Payments Exceed Deductible and Coinsurance on Assigned Claims**

DMERCs pay the patient under the procedure described in MCM §7057 where the patient's payments on an assigned claim exceed the deductible and coinsurance applicable to the allowed charges.

They pay benefits to the supplier first. After the supplier has been paid, DMERCs pay the beneficiary so that the payments to the supplier plus the amount paid by the beneficiary equal the fee schedule for the purchase of the equipment. The patient is paid according to the amount by which the deductible and coinsurance were overpaid.

The supplier may prefer to delay charging the beneficiary until the amount of deductible and coinsurance are known. Any payments which have been made, however, should be shown in Item 29 of the Form HCFA-1500 or Item 10 of the Form HCFA-1490.

## **6 – Evidence of Medical Necessity - Oxygen Claims**

If DMERCs learn that the physician of record is no longer the treating physician, the supplier must be directed to obtain from the physician currently responsible for the patient's pulmonary condition a current, fully completed CMN. After review of this CMN, DMERCs continue monthly payments if the evidence establishes medical necessity. Their records must be updated to identify the new treating physician and, if necessary, adjust the schedule for further re-certifications.

## **7 – Advance Determination of Medicare Coverage (ADMC) of Customized DME**

Section 1834(a)(15)(C) of the Act provides that carriers shall, at the request of a supplier or beneficiary, determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered if:

- The item is a customized item, and
- The patient to whom the item is to be furnished, or the supplier, requests that such advance determination be made.

This section provides for direction in implementing § 1834 (a)(15)(C) of the Act.

It is important to note that ADMCs are not initial determinations as defined at 42 CFR 405.801(a), because no request for payment is being made. As such, ADMC cannot be appealed.

### **7.1 – Definitions**

#### **7.1.1 – Definitions of Customized DME**

Section 1834(a)(4) of the Act and 42 CFR 414.224 define customized DME as being **uniquely constructed or substantially modified** for a specific beneficiary according the description and orders of a physician and be so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

For instance, a wheelchair which has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.

### **7.2 – Items Eligible for ADMCs**

The DMERCs are no longer required to provide ADMCs for transcutaneous electrical nerve stimulators, seat lift mechanisms or power operated vehicles. DMERCs may, at their discretion, continue to provide ADMC for these items if they feel that providing such a service will provide appropriate levels of customer service.

The DMERCs shall publish examples of the types of items for which ADMCs are available. These examples shall be published in each year's October DMERC Supplier Bulletin. Examples are not intended to be all-inclusive; instead, they should provide a general idea of the types of items for which this type of determination is available.

### **7.3 – Instructions for Submitting ADMC Requests**

At their option, suppliers or beneficiaries may submit, in hard copy, requests for ADMC. Requests must contain adequate information from the patient's medical record to identify the patient for whom the item is intended, the intended use of the item, and the medical condition of the patient which necessitates the use of a customized, rather than a pre-fabricated item.

Each DMERC shall publish the mailing address to which requests should be sent in each quarterly supplier bulletin.

### **7.4 – Instructions for Processing ADMC Requests**

Within 3 working days of receipt of a request, the DMERC must determine if the request contains adequate information upon which to make the determination. If additional information is required, the DMERC shall request the needed information from the supplier of the item.

Upon receipt of a complete request, the DMERC shall render an advance determination of Medicare coverage within 15 working days. DMERCs shall provide the requestor with their decision, be it affirmative or negative, in writing.

### **7.5 – Affirmative ADMC Decisions**

When making an ADMC, the DMERC should review the information submitted with the request to determine; 1) if a benefit category exists, 2) if a statutory exclusion exists, and 3) if the item is reasonable and necessary.

An affirmative ADMC decision will provide the supplier and the beneficiary assurance that the item, based on the information submitted with the request, will be **covered** by the Medicare program. An affirmative ADMC decision does not provide assurance that the beneficiary meets Medicare **eligibility** requirements. Only upon submission of a complete claim, can the DMERC determine an individual beneficiary's eligibility. Similarly, an affirmative ADMC decision does not extend to the **price** that Medicare will pay for the item.

An affirmative ADMC decision is valid for a period of 90 calendar days from the date the decision is rendered. Oftentimes, beneficiaries who require customized DME are subject to rapid changes in medical condition. These changes may obviate the need for a particular item, either because the beneficiary's condition improved or deteriorated. For this reason, the date the item was provided to the beneficiary cannot be more than 90 days after the date the ADMC decision was made.

The DMERCs reserve the right to review claims on a pre- or post-payment basis and, notwithstanding the requirements of this section, may deny claims and take appropriate remedy if they determine that an affirmative ADMC decision was made based on incorrect information.

### **7.6 – Negative ADMC Decisions**

A negative ADMC decision communicates to the supplier and the beneficiary that, based on the information submitted with the request, Medicare will not cover the item. The negative ADMC decision should indicate why the request was denied.

A negative ADMC decision does not have bearing on an individual beneficiary's eligibility, or on the price for which Medicare will pay for the item.

A beneficiary or a supplier can resubmit an ADMC request any time that additional information, including but not limited to additional medical documentation or documentation of a change in condition exists which could affect a negative ADMC decision. When this occurs, the DMERC shall treat the resubmitted ADMC request as a new ADMC request.

## **7.7 – DMERC Tracking**

DMERCs shall develop the capability to track ADMC requests in order to assure that decisions are rendered in a timely and appropriate fashion. DMERCs shall also develop the capability to ensure that 1) items for which an affirmative ADMC decision was made are not denied as not covered, and 2) claims for item that received a negative ADMC decision are denied as not covered, unless additional medical documentation submitted with the claims supports coverage.

Because this is a voluntary program, DMERCs shall review claims for items for which an ADMC request was not made and process those claims based on the medical necessity of the items.

# Medicare Program Integrity Manual

## Chapter 6 B Intermediary MR Guidelines for Specific Services

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## **1 - MR for Coverage of SNF Services{tc \11 '1 -- MR for Coverage of SNF Services}**

Intermediaries review SNF claims with supporting medical record documentation to ensure that payment is made only for services that are reasonable and necessary, for services for patients that require a skilled level of care on a daily basis, and, as a practical matter, for services that can only be provided on an inpatient basis in a SNF. They review each service for which payment is requested.

"Rules of thumb" in the MR process are prohibited. Intermediaries must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any "rules of thumb" that would declare a claim not covered solely on the basis of elements such as lack of restoration potential, ability to walk a certain number of feet, or degree of stability is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decision must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.

Intermediaries identify admissions where it appears that the beneficiary has been prematurely discharged from an acute care hospital. They identify cases where other quality of care issues appear and refer quality issues, other than those in Subsection A below, to the RO for referral to the State agency.

### **A - Premature Discharge From Prospective Payment System (PPS) Setting**

Intermediaries refer cases to the RO where evidence indicates a patient was prematurely discharged from the PPS acute care setting, admitted to a swing bed or hospital-based SNF, and the patient continued to require and receive acute care services. Based upon review of the medical record, intermediaries determine whether:

- The patient received any SNF services during the stay;
- If so, at what point the patient began receiving them;
- The total number of SNF days, if any, during which the patient received SNF services; and
- The dates the SNF services were rendered, if applicable.

All information (e.g., medical record) used in the review determination must be attached.

The RO forwards the material to the PRO for its review of the alleged premature discharge and the acute care services. The PRO determines if, in fact, the patient was prematurely discharged, and the number of acute care days billed as SNF days. They inform the intermediary of the number of days and dates of service to deny. The PRO issues a denial notice to the provider and informs the beneficiary of the number of days counted as hospital days for utilization purposes. The SNF payment must be treated as an overpayment.

## **1.1 - MR of Hospital-Based and Nonhospital-Based SNF Claims {tc \12 "1.1 -- MR of Hospital-Based and Nonhospital-Based SNF Claims }**

### **A - Covered Services: Claims Submitted for Payment of SNF Services**

The level of review is determined by the budgeted funds available for MR. Intermediaries must use the selection criteria for focused review outlined in the PIM Chapter 2, §2.4.3.1. A copy of the screens or parameters used to select bills for review must be furnished with the report of MR activity and a new copy furnished whenever intermediaries make changes in the selection process. They complete the review as follows:

- Request appropriate medical records (i.e., medical information forms or copies of medical records) covering the period, or to discharge, as appropriate, a copy of the beneficiary notice and the basis for the determination when a SNF continued stay denial falls in the sample.
- Review and determine the medical necessity of the admission and appropriateness of the continued stay. If the reviewer reverses the SNF non-coverage decision, a notice must be sent to the beneficiary and to the provider. A bill must be requested for the period reversed or adjust the bill submitted. (See MIM §3723.) If the intermediary affirms the SNF non-coverage decision, a denial notice with appropriate waiver and appeals language must be sent.
- Increase the review for the next quarter if the intermediary identifies, in more than 10 percent of the bills, improper coverage or non-coverage decisions. This intensified review is counted in the 20 percent mandated review.
- Train the SNF if inaccurate decisions are being made.

### **B - Demand Bills**

Intermediaries conduct MR of all patient generated demand bills with the exception noted below. Demand bills are bills submitted by the SNF at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and wishes the bill to be submitted for a payment determination. The demand bill is identified by condition code 20. The SNF must have a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request. (See 42 C.F.R. 424.36.)

In medically reviewing demand bills, intermediaries must use summary forms whenever available. If the intermediary is not currently using such a form, they should begin using one in place of submission and review of medical records.

The reasons for non-coverage of services decisions made by the SNF must be present on the medical information summary form. If a summary form is not being used, the SNF must submit a copy of the denial letter with the reason for non-coverage.

Demand bills are submitted in the next billing cycle after the beneficiary's request. They are subject to the CPT standards set for payment claims. Intermediaries must review the demand bill, the medical information and reasons for non-coverage of services to assure that the SNF is making correct determinations. Also, they review the non-coverage letter, when present, for timeliness and content.

If the intermediary concurs that the care is not covered, it sends the appropriate denial letter. It includes the appeal rights statement. If the intermediary reverses the determination, in whole or in part, it notifies the beneficiary and the SNF in writing.

Intermediaries must train the SNF if inaccurate decisions are being made.

Demand bills for services to beneficiaries who are not entitled to Medicare or do not meet eligibility requirements for payment of SNF benefits (i.e., no qualifying hospital stay) do not require MR. A denial notice with the appropriate reasons for denial must be sent.

### **C - Bills Submitted for Medicare Denial Notices**

Providers may submit bills for denial notice from Medicare for Medicaid or another insurer that requires a medical denial letter. These bills are identified by condition code 21. The bill must be accompanied by a copy of the beneficiary notice of noncoverage that includes the specific reasons the services were determined to be noncovered. In this situation, intermediaries send a denial letter with appeal rights to the beneficiary and a copy to the SNF.

### **1.2 - Review of Observation and Assessment and Management and Evaluation in SNFs {tc 12 "1.2 -- Review of Observation and Assessment and Management and Evaluation in SNFs}**

#### **A - General**

Intermediaries must use these MR guidelines in conjunction with the Medicare SNF coverage guidelines and policy training guidelines. As stated in the policy training guidelines, intermediaries review for coverage. Where coverage is not present, no Medicare payment is to be made.

All SNFs are required by regulation to assess each patient, identify their needs, and develop an individual care plan to meet the needs. (See 42 CFR 483.20.) Many patients in SNFs require some skilled services and skilled nursing oversight to ensure that the patient care plan is carried out.

The purpose of these MR guidelines is to help the intermediary distinguish between patients who require daily skilled observation and assessment or management and evaluation and patients who require periodic skilled services on a less than daily basis and/or a supportive environment and oversight to ensure their general well being. In determining the appropriate extent of review for a particular claim, intermediaries must keep the following in mind:

- Cover a claim once sufficient indicators exist to establish that it meets level of care requirements; and
- Deny a claim only after the reviewer has completed review of **all** aspects of the claim without finding sufficient indicators to establish coverage.

### **B - Observation and Assessment Definition**

Observation and assessment is reasonable and necessary when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures. It is needed until the patient's treatment regimen is essentially stabilized. The need for skilled observation and assessment is driven also by the inherent complexity of planned services and their impact on the patient's overall condition.

### **C - Indicators of the Need for Skilled Observation and Assessment**

The determination of Medicare coverage includes consideration of many factors. These factors in combination could indicate the potential for a change in the patient's condition resulting in the need for treatment and plan of care modification. Factors intermediaries consider in evaluating the need for skilled observation and assessment include:

- Condition of the patient at discharge from acute facility;
- Consideration of factors that may indicate medical instability, e.g., changes to medications or unstable laboratory values; and
- Multiple medical problems that are likely to interact to create complications or acute episodes.

### **D - Documentation to Support Coverage**

There must be documentation of instability or the probability of a change in the patient's condition. The presence of any one or more of the following is sufficient:

- A nursing care plan that describes the patient's condition, specifies problems or potential problems and planned intervention on a daily or more frequent basis;
- Indication of daily or more frequent monitoring of vital signs, description of lung or bowel sounds and skin condition, deficiencies in nutritional status and hydration, mental status and mobility related to the instability or probable changes in condition. This information documents that there is ongoing observation and assessment of the patient;
- Documented changes in the patient's vital signs, nutritional status, skin condition, etc. that reflect instability. Lack of changes in physical condition does not, in itself,

preclude the need for observation and assessment. Documentation must support that there is a reasonable probability for changes in the patient's condition; and

- Repeated modifications in the treatment plan as a result of changes in the patient's condition.

**EXAMPLE 1:** The following is an example of a patient who would require daily skilled observation and assessment:

The patient has unstable diabetes with fluctuating blood glucose levels and resulting symptoms of both hyperglycemia and hypoglycemia occurring intermittently. Assessment of these symptoms is required each shift by an R.N. or L.P.N.. The patient's blood glucose level is ordered to be checked via fingerstick and sliding scale insulin given twice a day, as well as, the patient receiving both a.m. and p.m. insulin. Because of the instability of the patient's diabetic condition, observation and assessment of symptoms, food intake, and blood glucose is required by a professional every four to eight hours.

In contrast, the following claim contains indicators of the need for further review.

**EXAMPLE 2:** The patient has diabetes that is controlled with an oral hyper-glycemic medication such as Diabinese and diet (elimination of concentrated sweets). The patient's blood sugar is well controlled by medication and diet modification, and a fasting blood glucose is done every 3 months for monitoring purposes. The intermediary must deny only if a review of **all** aspects of the claim fails to reveal sufficient indicators of the need for skilled observation and assessment described above (or any other skilled service) to establish coverage.

The following is a patient who requires skilled observation and assessment:

**EXAMPLE 3:** The patient has Alzheimer's dementia that is progressing at a rapid rate. Behaviors are unstable and inconsistent. This requires continuous monitoring with both behavioral and medication intervention frequently to increase the functional capability of the patient.

By contrast, example 4 contains indicators of the need for further review.

**EXAMPLE 4:** The patient is newly diagnosed with multi-infarct dementia, secondary to a resolved cerebrovascular accident. However, behaviors related to dementia are stable and consistent, mainly forgetfulness, so that the patient needs a reminder to dress and when to eat. A denial is appropriate only if a review of **all** aspects of the claim fails to reveal sufficient indicators of the need for skilled observation and assessment described above (or any other skilled service) to establish coverage.

## **E - Management and Evaluation Definition**

The development, management, and evaluation of a patient care plan, based on the physician's orders, constitutes skilled nursing services when these services require the involvement of skilled personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. Skilled personnel are required for planning and management of a treatment plan where the patient's overall condition supports a finding that recovery and safety can be assured only if the total care, skilled or not, is planned and managed by the nurse.

## **F - Indicators of the Need for Skilled Management of Unskilled Services**

Factors intermediaries consider in determining the need for skilled management and evaluation include:

- Documented medical symptoms (not just diagnoses) and concerns related to the symptoms which have the potential for serious complications;
- Documented functional deficits, physical or mental or other health risk behaviors which would complicate the care of the medically at risk patient (e.g., bed confined, poor nutrition, dehydration, confusion);
- Presence of a treatment plan that requires daily or more frequent intervention and requires that a skilled professional evaluate the effectiveness of the interventions on a daily basis;
- History of frequent hospitalizations or emergency room visits related to falls, dehydration, and malnutrition;
- Would the condition of the patient deteriorate or recovery be impeded if the beneficiary did not have a skilled nurse managing the care on a daily basis, i.e., what would happen to the patient if there was not daily skilled management of the treatment plan? If daily skilled management is not required, does the patient require other skilled services that together with the need for skilled management result in daily skilled care?
- Are the services required by the patient interrelated? Is a medical professional needed to understand the relationship?
- If a patient did not require skilled management and evaluation prior to an acute episode, but receives it after the acute episode is resolved, is the skilled management and evaluation justified by an actual change in the patient's condition (and not furnished merely because of the occurrence of the acute episode itself)?
- Type, number, and complexity of services, being furnished on a daily basis; and
- Changes in the care plan or physician's orders.

Documentation must reflect the patient's condition and medical needs, the treatment regimen and evidence of the potential for serious complication. Documentation that may support coverage include the following:

- A description of medical problems, and related concerns for the patient;
- Multiple entries or other evidence that reflect concern with patient's recovery or risks/potential complications if patient's care is not carefully supervised;
- Evidence that nurses/therapists are assessing or supervising results of care that is given by non-skilled personnel and verifying that the care is furnished; and
- A care plan that clearly shows the complexity of the care required.

**EXAMPLE 1:** The following is one example of a patient who needs skilled management of unskilled services:

The patient has a diagnosis of Alzheimer's disease that is in final stages. Documented medical problems include weight loss, dehydration, and frequent symptomatic urinary tract infections. These problems are all related to functional declines that can occur in patients at this stage of Alzheimer's disease. This requires continuous planning of various interventions to maintain adequate food and fluid intake, and evaluation of effectiveness of approaches. Monitoring of urine output and prompt treatment of any infections is also required.

**EXAMPLE 2:** In contrast, the following claim contains indicators of the need for further review:

The patient has diagnoses of congestive heart failure, peripheral vascular disease, gout, non-insulin dependent diabetes and is legally blind. Although the combination of these diagnoses suggests a potential risk to the patient, the patient's condition is stable and asymptomatic. The care described consists of assisting the patient from bed to chair several times a day, and assistance with meals and activities of daily living. The physician monitors the general condition of the patient and does a medication review and adjustment every 3 months. A denial is appropriate only if a review of **all** aspects of the claim fails to reveal sufficient indicators of the need for skilled management and evaluation described above (or any other skilled service) to establish coverage.

## **G - Sources of Documentation**

Medical information forms that clearly describe the information needed to make a coverage decision include:

- Hospital discharge summaries and transfer forms;

- Physician orders and progress notes;
- Patient care plans;
- Patient assessment instrument (MDS/MDS+);
- Nursing and rehabilitation therapy notes; and
- Treatment and flow sheets (include nurses' aide) and vital sign records, weight charts and medication records.

## **H - Other Considerations**

The need for skilled observation and assessment or management and evaluation may end when the medical condition is stabilized, the patient recovers from the acute condition, or the treatment plan is well established and risks to the patient are minimized.

In some instances, skilled observation and assessment and management and evaluation overlap in their functions and definitions. However, the reviewer must require specific evidence of the need for skilled management and evaluation.

## **2 - MR of Hospice Claims {tc \11 "2 -- MR of Hospice Claims }**

Hospice care is a concept of care and services for the terminally ill patient that offers an alternative to traditional therapeutic treatment that may no longer be appropriate or desirable.

To assure that appropriate payments are made for services provided to individuals electing hospice care, the intermediary is required to request and review medical records (including the written plans of care) from hospice providers. This section describes procedures to be followed in medical review (MR) of hospice claims.

Intermediaries conduct MR of hospice claims to:

- Insure that the services provided were stipulated in the plan of care;
- Determine whether the services provided were necessary for the palliation or management of the beneficiary's terminal illness;
- Insure that the services were adequately provided and were appropriately classified for payment purposes as specified in MIM §3672;
- Insure the services provided were covered hospice services; and,
- Insure that inpatient hospice services provided in a hospital are billed by the hospice.

They conduct the review based on the focused review criteria outlined in PIM chapter 2 §2ff and select claims for review that permit the most cost effective review.

The intermediary will request medical records and documentation necessary for the review from the hospice and deny claims if the records are not received within 30 days of the date requested. If a claim is denied because the medical documentation was not received within 30 days, the hospice is liable for the costs of the noncovered services.

In addition, the intermediary may, at times, find it necessary to access information at the provider site. Any records related to a beneficiary must be made available. The intermediary may also find it necessary to visit the beneficiary and/or relatives at home to verify that Medicare payment is appropriate. At the time the beneficiary elects hospice benefits, they are asked to sign a separate form consenting to Medicare home visits. However, if the patient refuses to sign the consent form, hospice benefits are not affected. The consent form (See Section A below for a copy of the form) makes both the hospice and the patient aware of the possibility of such visits and the fact that the visits are necessary to determine the quality of delivered health care services. The consent form makes it clear that the patient and/or the family member has the right to refuse entry at any given time.

As a result of MR, an intermediary may reclassify care from one rate category to another. For example, if continuous home care was provided to a patient whose condition did not require the level of care described in (Hospice manual) §230.2 (or did not receive it), the intermediary makes payment for the services at the routine home care rate.

**A B Hospice Home Visit Consent Form**

1. Patient's Last Name	First Name	MI	2. Health Insurance Claim Number
3. Patient's Address (Street number, City, State, Zip Code)		4. Date of Birth	5. Sex M F
6. Hospice Name and Address (City and State)		Provider Number	
8. Date of Hospice Election			

This consent form permits the FI MR personnel to conduct home visits with you and/or your family members in order to ensure that quality care is provided and that Medicare payments for the services received are appropriate.

You and/or your family members have the right to refuse entry into your home at any time. Refusal to sign the home visit consent form or to permit entry into your home after consent is given will not affect payment for hospice services.

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I understand the explanation described above and give my permission for home visits.

---

Beneficiary  
Signature

Date

---

Signature of Hospice Representative

**2.1 - Review of Routine Home Care, Inpatient Respite, General Inpatient , and Continuous Care Claims {tc \l2 "2.1 -- Review of Routine Home Care, Inpatient Respite, General Inpatient , and Continuous Care Claims }**

There is no requirement for a minimum level of review. Intermediaries must review claims in areas where inappropriate billing is determined. They focus on certain hospices where inappropriate billing is identified or on new hospices in order to ensure appropriate understanding of coverage criteria.

Intermediaries must review hospice claims as follows:

- Review the written plan of care and medical record for continuous care claims. They determine whether the beneficiary needed and received continuous care services (i.e., more than 50 percent skilled nursing care);
- If the medical records do not support that continuous care services were necessary for the palliation or management of the individual's terminal illness during periods of crises, intermediaries deny the claim for continuous home care and adjust payment accordingly;
- Determine whether or not the services provided were related to the individual's terminal illness and stipulated in the plan of care;
- If a review of medical records indicates that services provided were medically necessary and appropriate for the control of pain or acute or chronic symptom management as outlined in the individual's plan of care, intermediaries approve the claim; and

- If the review indicates that inpatient or continuous home care services provided were not stipulated in the patient's plan of care, as established by the interdisciplinary group, intermediaries deny the claim and reduce payment accordingly.

## **2.2 - Review of Hospital Claims for Hospital Admissions of Beneficiaries Who Have Elected Hospice Care {tc \12 "2.2 -- Review of Hospital Claims for Hospital Admissions of Beneficiaries Who Have Elected Hospice Care }**

At the time of election of hospice care, patients waive coverage of non-hospice services related to the terminal illness. All general inpatient care for the terminal illness provided to hospice patients is to be billed by the hospice. Intermediaries must identify and review every claim from acute hospitals for beneficiaries who have elected hospice care to assure that:

- Non-hospice Medicare payment is provided for these beneficiaries only when hospitalization is for a condition not related to the terminal illness; and
- Claims are denied and the beneficiaries are held financially liable when beneficiaries are hospitalized for conditions related to their terminal illness.

### **A - Hospital Claims Review for Beneficiaries Who Have Elected Hospice Care**

Claims should be referred for MR when a decision as to whether the services are related to the terminal illness must be made by a health professional. Initial review should be a clerical or automated review. A determination must be made as to whether services provided were related to the individual's terminal illness. When an individual is terminally ill, many illnesses may occur which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition.

If the review indicates that hospitalization is related to the individual's terminal illness, the claim must be denied. The right to payment for these non-hospice services is waived with the hospice election. Waiver of liability does not apply to these denials. If the review indicates that the hospitalization is unrelated to the individual's terminal illness, intermediaries process the claim.

### **B - Follow-up Procedures**

If hospice deficiencies are identified as a result of MR, intermediaries must report them to the RO for follow-up action by the State agency or other appropriate agency. Deficiencies include, but are not limited to:

- Failure to follow the patient's plan of care;
- Inappropriate discharges;
- Under-provision of services; or

- Failure to furnish services.

### **3 - MR of Home Health Services(tc \11 "3 -- MR of Home Health Services}**

Standardized data collection promotes more consistent coverage decisions and minimizes payment for non-covered services. The home health data elements are contained on Form HCFA-485, Home Health Certification and Plan of Care. It contains data necessary to meet regulatory and national survey requirements for the physician's plan of care and certification. This form is completed by the physician/HHA.

HHAs are required to obtain a signed HCFA-485 as soon as practical after the start of care and prior to submitting a claim to the RHHI. The HHA may provide services prior to obtaining the physician's written plan of care based on documented verbal orders. If care continues beyond the certification period (usually 2 months, but no longer than 62 days), the HHA must obtain a re-certification from the physician. The signed HCFA-485 is maintained in the provider's files with a copy of the signed form available upon request when needed for MR of selected claims (e.g., the agency has been identified in the FMR process as requiring review of claims or specific services).

Where the information on the HCFA-485 may not be sufficient to make a determination, intermediaries must request whatever additional information or copies of pertinent medical records that may be necessary.

Providers may submit Form HCFA-485 via electronic media if acceptable to the intermediary.

In reviewing the HCFA-485 and/or other medical information, the RHHI makes a determination on the entire certification period or beyond if services are continued. If the RHHI determines that services are non-covered from the Start of Care (SOC) or at some point during the billing period, the RHHI must ensure the appropriate controls are in place so that subsequent claims are suspended for appropriate action.

RHHIs may deny visits/services based upon information provided on the form. However, additional information or a copy of the medical record must be requested when objective clinical evidence needed to support a decision is not clearly present. (See MIM §3116.1.) RHHIs do not deny claims because a field on the HCFA-485 has not been completed. If the missing information is needed to make a coverage determination, it must be requested. If a coverage determination can be made despite the missing information, they pay the claim if the services are clearly covered or, deny it if they are clearly not covered. It is appropriate to deny the claim if the missing information needed for a coverage determination is not submitted within 35 days of the date of the request for documentation or if the agency indicates that the information is not available. Follow the procedures for the items noted.

- Missing or Incomplete Physician's Orders
  - Visits for a discipline are billed but there is no physician order, or the physician order is present but is not specific, or there is no frequency.

- RHHIs request a copy of the physician's order for the services. RHHIs accept a documented verbal order or signed written order. (See below for Acceptable Verbal Orders.) They do not accept orders signed after the service(s) is rendered unless there is evidence of a pre-existing verbal order. If the agency is furnishing services without a physician's order, deny the services. RHHIs advise the HHA that the findings will be reported for possible referral to the State survey office.
- Physician's order for discipline and frequency is present but there is no duration of visits.
  - RHHIs make a medical necessity determination on the duration billed.
- Agency provides fewer visits than the physician orders.
  - RHHIs do not deny claims because the agency provides fewer visits than ordered. The agency should be reporting decreases in visits to the physician. Where an agency is consistently decreasing visits without reporting to the physician, notify the RO so that the State survey office can be advised.
- Documentation of physician's verbal orders. Accept any of the following:
  - Receipt of verbal orders is identified by the signature of a registered nurse, qualified therapist (i.e., physical therapist, speech language pathologist, occupational therapist, or medical social worker), or any other health professional responsible for furnishing or supervising the patient's care and the date in Item 23 of Form HCFA-485, and the form is signed by the physician;
  - Form HCFA-485 is signed by the physician and contains the verbal order(s) which has been written, signed, and dated in the clinical record;
  - The form on which the verbal order is written, signed, and dated by agency staff is countersigned by the physician; or
  - A document signed by the physician contains the written, signed, and dated verbal order in the clinical record

There are no required forms or format for documentation or confirmation of verbal orders. In the absence of documentation of verbal orders, RHHIs accept a notarized statement from the physician that he/she gave verbal orders before the services were rendered.

- Physician Certification/Re-certification:
  - RHHIs investigate whether the physician certifying or re-certifying the need for home health services has a financial interest or ownership in HHAs.

- The RHHI must obtain a list of physicians and their UPINs associated with HHAs in the servicing area. Update this list once a year. HHAs are responsible to notify the RHHI of any changes in ownership or financial interest in the interim. (See MIM §3604.)
- The RHHI must automate the list and establish edits to match against the UPIN. Reject and/or deny claims that show a matching UPIN.

### 3.1 - HCFA-485 - Home Health Certification and Plan of Care Data Elements {tc \12 "3.1 -- HCFA-485 - Home Health Certification and Plan of Care Data Elements }

The form HCFA 485 meets the regulatory requirements (State and Federal) for the physician's plan of care and certification and re-certification requirements. HHAs are required to obtain a signed HCFA-485 as soon as practical after the start of care and prior to submitting the claim. The HHA may provide services prior to obtaining the physician's written plan of care based on documented verbal orders. If care continues beyond the certification date, the HHA must obtain a re-certification from the physician. The signed HCFA-485 is maintained in the provider's files.

The following items are contained on the HCFA-485:

<u>No</u>	<u>Data Element</u>	<u>Description</u>
1	Patient's HICN	The HICN (numeric plus alpha indicator(s)) as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the SSO.
2	SOC Date	The HHA enters the 6 digit month, day, year on which covered home health services began, i.e., MMDDYY (101598). The SOC date is the first Medicare billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home health may be suspended and later resumed under the same SOC date in accordance with the HHA's internal procedures.
3	Certification Period	The HHA enters the 2 digit month, day, year, i.e., MMDDYY (10/15/98-12/15/98), that identifies the period covered by the physician's plan of treatment. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed 2 calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent re-certification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period.

**EXAMPLE:** Initial certification "From" date 101598: Initial certification "To" date 121598:

Re-certification "From" date 121598: Re-certification "To" date 021599

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| 4  | Medical Record No                         | This is the patient's medical record number that is assigned by the HHA and is an <b>optional</b> item. If not applicable, the agency enters "N/A."            |
| 5  | Provider No.                              | This is the 6 digit number issued by Medicare to the HHA. It contains 2 digits, a hyphen, and 4 digits (e.g., 00-7000).  |
| 6  | Patient's Name and Address                | The HHA enters the patient's last name, first name, and middle initial as shown on the health insurance card and the street address, city, State, and ZIP code |
| 7  | Provider's Name, Address and Telephone No | The HHA enters its name and/or branch office (if appropriate), street address (or other legal address), city, State and ZIP code and telephone number.         |
| 8  | Date of Birth                             | The patient's date of birth (6 digit month, day, year) in numbers, i.e., MMDDYY (040320) is entered.   |
| 9  | Sex                                       | The patient's sex is checked in the appropriate box.   |
| 10 | Medications: Dose, Frequency, Route       | The physician's orders for all medications including the dosage, frequency and route of administration for each drug must be listed.                           |

Drugs which cannot be listed on the plan of care due to lack of space are listed on the addendum.

- The letter "N" is used after the medication(s) that are "new" orders.
- The letter "C" is used after the medication(s) that are "change" orders either in dose, frequency or route of administration.
- "New" medications are those that the patient has not taken recently, i.e., within the last 30 days.
- "Change" are medications which include dosage, frequency or route of administration changes within the last 60 days.

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| 11 | Principal Diagnosis, ICD-9-CM Code and Date of Onset, Exacerbation | The principal diagnosis is entered on all HCFA-485s. The principal diagnosis is the diagnosis most related to the current plan of care. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated |
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concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered.

The HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. V codes are acceptable as primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition.

**EXAMPLE:** Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis since V57.1 does not specify the type or location of the fracture. Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the proposed services.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

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| 12 | Surgical Procedure, Date, ICD-9-CM Code | The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.62, Insertion of Austin Moore Prosthesis, 060998). If a surgical procedure was not performed or is not relevant to the plan of care, N/A is inserted. The addendum (HCFA-487) is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery. |
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If a surgical procedure was not performed or is not relevant to the plan of care, N/A is inserted. The addendum is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

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| 13 | Other Pertinent Diagnoses: Dates of Onset/Exacerbation, ICD-9-CM Code | All pertinent diagnoses, both narrative and ICD-9-CM Codes, relevant to the care rendered are entered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently. Diagnoses that relate to an earlier episode, which have no bearing on this plan of |
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treatment, are excluded.

If there are more than the four pertinent diagnoses, the addendum is used to list the additional conditions. The agency enters N/A if there are no pertinent secondary diagnoses. The date reflects the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis. If the date is unknown, the agency notes the year and places 00s in the month or day not known.

- 14      DME and Supplies      All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require use of the specific supplies. The HHA enters in this item non-routine supplies that it is billing to Medicare that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley, catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require use of non-routine supplies which would vary by patient. Therefore, the non-routine supplies would be listed.

If the HHA lists a commonly used commercially packaged kit, it is not required to list the individual components. However, if there is a question of cost or content, the RHHI can request a breakdown of kit components.

RHHIs should reference the Provider Reimbursement Manual, §2115 for a definition of non-routine supplies.

The HHA also lists DME ordered by the physician that will be billed to Medicare. The HHA enters N/A if no supplies or DME are billed.

- 15      Safety Measures      The physician's instructions for safety measures are listed.
- 16      Nutritional Requirements      The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total parenteral nutrition (TPN) can be listed under this item or under medications if more space is needed.
- 17      Allergies      Medications to which the patient is allergic are listed. In addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are included.
- 18A      Functional Limitations      All items that describe the patient's current limitations as assessed by the physician and the agency are indicated.
- 18B      Activities Permitted      The activity(ies) that the physician allows and/or for which

physician orders are present are indicated.

If "Other" is checked under Item 18A or 18B, a narrative explanation is required.

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| 19 | Mental Status | The block(s) most appropriate to describe the patient's mental status is checked. If "Other" is checked, the patient's condition is specified here. |
| 20 | Prognosis     | A check is placed in the box which specifies the most appropriate prognosis for the patient; poor, guarded, fair, good or excellent.                |

**NOTE:** The number or letter adjacent to the blocks in Items 18 through 20 corresponds to the codes for EMC transmission only.

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| 21 | Orders for Discipline and Treatments (Specify Amount, Frequency, Duration) | The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/treatments to be performed by each discipline must be stated. A discipline may be one or more of the following: SN, PT, ST, OT, MSS, or AIDE. |
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Orders must include all disciplines and treatments, even if they are not billable to Medicare. In general, the narrative explanation for applicable treatment codes is acceptable as the order when that narrative is sufficiently descriptive of the services to be furnished. (See PIM Chapter 6 §3.2.). However, additional explanation is required in this item to describe specific services, i.e., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. Additional explanation is also required where the physician has ordered specific treatment, medications or supplies. When aide services are needed to furnish personal care, an order for "personal care" is sufficient. See example of orders below.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

A range of visits may be reflected in the frequency (e.g., 2 to 4 visits per week). When a range is used, consider the upper limit of the range the specific frequency. An agency may use ranges if acceptable to the physician without regard to diagnosis or other limits.

Example of Physician's Orders: Certification period is from 10/15/98 - 12/15/98:

OT - Eval., Activities of Daily Living (ADL) training, fine motor coordination 3x/wk x 6wks

ST - Eval., speech articulation disorder treatment 3x/wk x 4wks

SN - Skilled observation and assessment of C/P and neuro status instruct meds and diet/hydration 3x/wk x 2wks

MSS - Assessment of emotional and social factors 1x/mo x 2mos

AIDE - Assist with personal care, catheter care 3x/wk x 9wks

Specific services rendered by physical, speech and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are heat, sound, cold, and electronic stimulation.

**EXAMPLE:** PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2wks.

PRN visits may be ordered on a plan of treatment only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is specified in the plan of care. Open-ended, unqualified PRN visits do not constitute physician orders for patient care since neither the nature nor the frequency of the service is specified.

**EXAMPLE:** Skilled nursing visits 1xm x 2m for Foley change and PRN x 2 for emergency Foley irrigation and/or changes.

Skilled nursing visits 1xm x 2m to draw blood sugar and PRN x 2 to draw emergency blood sugar if blood sugar level is above 400.

22	Goals/Rehabilitation Potential/Discharge Plans	This reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.
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Examples of realistic goals:

- Independence in transfers and ambulation with walker;
- Healing of leg ulcer(s);
- Maintain patency of Foley catheter. Decrease risk of urinary infection;
- Achieve optimal level of cardiovascular status. Medication and diet compliance; and
- Ability to demonstrate correct insulin preparation/administration.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information should be pertinent to nature of the patient's condition and ability to respond. The words "Fair," or "Poor" alone, are not acceptable. Instead, descriptors must be added:

**EXAMPLE:** Rehabilitation potential is good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.

Where daily care has been ordered, the agency must be specific as to the goals and when the need for daily care is expected to end. Discharge plans include a statement of where or how the patient will be cared for once home health services are no longer provided.

- 23 Nurse's Signature and Date of Verbal Start of Care This verifies for surveyors, HCFA's representatives, and the RHHI that a registered nurse, qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker), or any health professional responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient. This date **may** precede the SOC date in Item 2 and may precede the "From" date in Item 3.

This field may be used to document receipt of verbal orders when services are furnished prior to the physician's written orders on SOC or re-certification. If this field is used, the order must be written on Form HCFA-485 and signed and dated with the date of receipt by the nurse, therapist, social worker, or qualified health professional to begin or modify care or continue care at re-certification.

This item is signed by the nurse, qualified therapist, social worker, or health professional responsible for the completion of Form HCFA 485, or by non-clerical personnel authorized to do so by applicable State and Federal laws and regulation as well as by the HHA's internal policies. The HHA enters N/A if the physician has signed and dated Form HCFA-485 on or before the SOC or re-certification date, or has submitted a written order to start, modify, or continue care on a document other than Form HCFA-485.

- 24 Physician's Name and Address The agency prints the physician's name and address. The attending physician is the physician who established the plan of treatment and who certifies and re-certifies the medical necessity of the home health visits and/or services. Supplemental physicians involved in a patient's care are mentioned on the HCFA-486 only. The physician must be qualified to sign the certification and plan of care in accordance with 42 CFR 424 Subpart B. Physicians who have significant ownership interest in, or a significant financial or contractual relationship with an HHA may not establish or review a plan of treatment or certify or re-certify the need for home health services.
- 25 Date HHA Received Signed Plan of Care (POC) The date the agency received the signed POC from the attending/referring physician is entered. It is required only if the physician does not date Item 27. The agency enters N/A if Item 27. DATE is completed.
- 26 Physician Certification This statement serves to verify that the physician has reviewed the plan of care and certifies to the need for the services.
- 27 Attending Physician's Signature and Date The attending physician signs and dates the plan of care/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending

physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature. HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, State surveyor, or other authorized personnel or in the event of a system breakdown.

The agency should not predate the orders for the physician, nor write the date in this field. If the physician left it blank, the agency should enter the date it received the signed POC under Item 25. An unsigned copy is submitted to you with the signed copy retained in the agency's files.

28      Penalty Statement      This statement specifies the penalties imposed for misrepresentation, falsification or concealment of essential information on the HCFA-485.

### **3.2 - Treatment Codes for Home Health Services{tc \l2 "3.2 -- Treatment Codes for Home Health Services}**

The agency may use the narrative explanation for the treatment codes which represent the services to be furnished. The narrative is entered in Item 21 of the HCFA-485. Additional narrative is required under Item 21 of the HCFA-485 to describe specific services, i.e., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. Non-asterisked items/services do not require additional narrative unless the physician has ordered specific treatment and/or use of prescription medications and/or non-routine supplies.

Listing of a code for a particular service is not intended to imply coverage. The codes are to ease identification of services ordered by the physician whether or not these services are payable individually by Medicare. Physician's orders reflect a narrative description of treatment and services to be furnished.

#### **A – SN**

These represent the services to be performed by the nurse. Services performed by the patient or other person in the home without the teaching or supervision of the nurse are not coded. The following is a further explanation for each service:

- A1. Skilled Observation and Assessment (Inc. V.S., Response to Med., etc.) Includes all skilled observation and assessment of the patient where the physician determines that the patient's condition is such that a reasonable probability exists that significant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.5.A.)
- A2. Foley Insertion Insertion and/or removal of the Foley catheter by nurse.
- A3. Bladder Instillation Instilling medications into the bladder.
- A4. Wound Care/Dressing Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (size and amount and type of drainage) in Item 16 on the HCFA-486. See A28 for observation uncomplicated surgical incision.
- A5. Decubitus Care Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance in Item 16 of the HCFA-486. They use this code only if the decubitus being treated presents the following characteristics:  
 1 – Partial tissue loss with signs of infection such as foul odor or purulent drainage;  
 2 -- Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.  
 For care of decubitus not meeting this definition, see A29.
- A6. Venipuncture The HHA specifies the test and frequency to be performed under physician's orders.
- A7. Restorative Nursing Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe non-skilled services (e.g, routine range of motion exercises).
- A8. Post Cataract Care Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See MIM §3117.5.A.)
- A9. Bowel/Bladder Training Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training is clearly identified.

A10	Chest Physio (Inc. postural drainage)	Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.
All	Adm. of Vitamin B/12	Administration of vitamin B-12 preparation by injection for conditions identified in Medicare guidelines.
A12	Prep/Adm. Insulin	Preparation of insulin syringes for administration by the patient or other person, or the administration by the nurse.
A13	Adm. Other IM/Subq	Administration of any injection other than vitamin B/12 or insulin ordered by the physician.
A14	Adm. IV's/Clysis	Administration of intravenous fluids or clysis or intravenous medications.
A15	Teach. Ostomy or Ileo Conduit Care	Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.
A16	Teach. Nasogastric Feeding	Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment and preparation of feedings.
A17	Reinsertion Nasogastric Feeding Tube	Includes changing the tube by the nurse.
A18.	Teach. Gastrostomy Feeding	Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.
A19	Teach. Parenteral Nutrition	Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.
A20	Teach. Care of Trach.	Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.
A21	Adm. Care of Trach.	Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.
A22.	Teach. Inhalation Rx	Teaching patient or other person to administer therapy and care for equipment.

A23	Adm. Inhalation Rx	Administration of inhalation treatment and care of equipment by the nurse.
A24	Teach. Adm. of Injection	Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching/administration of insulin. (See A12, A25.)
A25	Teach. Diabetic Care	Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing).
A26	Disimpaction/Follow-up Enema	Includes nursing services associated with removal of an impaction. Enema administration in the absence of an impaction only if a complex condition exists - e.g., immediate postoperative rectal surgery.
A27	Other (Spec. Under Orders)	Includes any SN or teaching ordered by the physician and not identified above. The agency specifies what is being taught in Item 21 (HCFA-485).
A28	Wound Care/Dressing	Skilled observation and care of surgical incision/suture line including application of DSD. (See A4.)
A29	Decubitus Care	Includes irrigation, application of medication and/or dressing changes to decubitus/other skin ulcer or lesion, other than that described in A5. The HHA describes size (depth and width) and appearance on the addendum.
A30	Teaching Care of Any Indwelling Catheter	Teaching patient or other person to care for indwelling catheter.
A31	Management and Evaluation of a Patient Care Plan	The complexity of necessary unskilled services require skilled management of a registered nurse to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
A32	Teaching and Training (Other)	Specify under physician orders.

**B - PT**

These codes represent all services to be performed by the physical therapist. If services are provided by a nurse, they are included under A7. The following is a further explanation of each service:

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| B1 | Evaluation                        | Visit(s) made to determine the patient's condition, physical therapy plans and rehabilitation potential; to evaluate the home environment to eliminate structural barriers and to improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides).  |
| B2 | Therapeutic Exercise              | Exercises designed to restore function. Specific exercise techniques (e.g., proprioceptive neuromuscular facilitation (PNF), Rood, Brunstrom, Codman's, William's) are specified. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion. |
| B3 | Transfer Training                 | To evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and care-givers in appropriate transfer techniques.  |
| B4 | Establish or Upgrade Home Program | To improve the patient's functional level by instruction to the patient and responsible individuals in exercise which may be used as an adjunct to PT programs.   |
| B5 | Gait Training                     | Includes gait evaluation and ambulation training of a patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic appliances, crutches, walker, cane, etc.).  |
| B6 | Pulmonary Physical Therapy        | Includes breathing exercises, postural drainage, etc., for patients with acute or severe pulmonary dysfunction.   |
| B7 | Ultra Sound                       | Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.  |
| B8 | Electro Therapy                   | Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (electromuscular stimulation, TENS, Functional Electrical Stimulation (FES), biofeedback, high voltage galvanic stimulation (HVGS), etc.).  |

B9	Prosthetic Training	Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.
B10	Fabrication Temporary Devices	Includes fabrication of temporary prostheses, braces, splints, and slings.
B11	Muscle Reeducation	Includes therapy designed to restore function due to illness, disease, or surgery affecting neuromuscular function.
B12	Management and Evaluation of a Patient Care Plan	The complexity of necessary unskilled services require skilled management by a qualified physical therapist to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
B13	Reserved	
B14	Reserved	
B15	Other (Spec. Under Orders)	Includes all PT services not identified above. Specific therapy services are identified under physician's orders (HCFA-485 Item 21).

**C - ST**

These codes represent the services to be performed by the speech therapist. The following is a further explanation of each.

C1	Evaluation	Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.
C2	Voice Disorders Treatments	Procedures and treatment for patients with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.
C3	Speech Articulation Disorders Treatments	Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements - usually referred to as apraxia/dyspraxia.
C4	Dysphagia	Includes procedures designed to facilitate and restore a functional

	Treatments	swallow.
C5	Language Disorders Treatments	Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.
C6	Aural Rehabilitation	Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.
C7	Reserved	
C8	Non-oral Communications	Includes any procedures designed to establish a non-oral or augmentive communication system
C9	Other (Spec. Under Orders)	ST services not included above. Specify service to be rendered under physician's orders (HCFA-485 Item 21).

## **D - OT**

These codes represent the services to be rendered by the occupational therapist. Following is a further explanation:

D1	Evaluation	Visit made to determine OT needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of care, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.
D2	Independent Living/Daily Living Skills (ADL training)	Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability
D3	Muscle Re-education	Includes therapy designed to restore function lost due to disease or surgical intervention.
D4	Reserved	
D5	Perceptual Motor Training	Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities which stimulate visual and kinesthetic channels to increase awareness of the body and its

movement.

D6	Fine Motor Coordination	Refers to the skills and the performance in fine motor and dexterity activities.
D7	Neurodevelopmental Treatment	Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses which are coordinated at subcortical and cortical levels.
D8	Sensory Treatment	Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and factory awareness necessary to increase function.
D9	Orthotics Splinting	Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.
D10	Adaptive Equipment (fabrication and training)	Refers to the provision of special devices that increase independent functions.
D11	Other	Occupational therapy services not quantified above.

## **E - MSS**

These codes represent the services to be rendered by the MSS worker. Following is a further explanation:

E1	Assessment of Social and Emotional Factors	Skilled assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.
E2	Counseling for Long-Range Planning and Decision making	Assessment of patient's needs for long term care including: evaluation of home and family situation; enabling patient/family to develop an in-home care system; exploring alternatives to in-home care; arrangement for placement.
E3	Community Resource Planning	The promotion of community centered services(s) including education, advocacy, referral and linkage.

E4	Short Term Therapy	Goal oriented intervention directed toward management of terminal illness; reaction/adjustment to illness; strengthening family/support system; conflict resolution related to chronicity of illness.
E5	Reserved	
E6	Other (Specify Under Orders)	Includes other MSS related to the patient's illness and need for care. Problem resolution associated with high risk indicators endangering patient's mental and physical health including: abuse/neglect, inadequate food/medical supplies; high suicide potential. The service to be performed must be written under doctor's orders (HCFA-485 Item 21).

## **F - AIDE**

These codes represent the services to be rendered by the AIDE. Specific personal care services to be provided by the AIDE must be determined by a registered professional nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. Following is a further explanation:

F1	Tub/Shower Bath	Assistance with tub or shower bathing.
F2	Partial/Complete Bed Bath	Bathing or assisting the patient with bed bath.
F3	Reserved	
F4	Personal Care	Includes shaving of patient or shampooing the hair.
F5	Reserved	
F6	Catheter Care	Care of catheter site and/or irrigations under nursing supervision.
F7	Reserved	
F8	Assist with Ambulation	Assisting the patient with ambulation as determined necessary by the nurse care plan.
F9	Reserved	
F10	Exercises	Assisting the patient with exercises in accordance with the plan of care.

F11	Prepare Meal	May be furnished by the aide during a visit for personal care.
F12	Grocery Shop	May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.
F13	Wash Clothes	This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate environment.
F14	Housekeeping	Household services incidental to care and that do not substantially increase the time spent by the home health aide.
F15	Other (Specify Under Orders)	Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified in Item 21 HCFA-485.

**3.3 - Addendum to Form HCFA-485 Plan of Care {tc \12 "3.3 -- Addendum to Form HCFA-485 Plan of Care }**

When additional space is needed to complete Form HCFA-485 fields, HHAs use an addendum identifying items 1-9.

To provide additional documentation of items on the POC or medical information form, the agency checks the appropriate block. It identifies the item being addressed on the addendum. For example, if the POC block is checked and Item 10 (medications) requires additional space, the HHA specifies Item (10) on the addendum. Upon completion of Item 10, it notes the next item number, e.g., Item 14, (DME) then completes that item.

Items 1 through 7 follow the same instructions found in the PIM Chapter 6 §3.1 for HCFA 485.

<u>No.</u>	<u>Data Element</u>	<u>Definition</u>
8	Signature of Physician	There must be a physician's signature or an annotation on the HCFA-485 which indicates that the physician is aware that he/she is signing for information contained on additional pages (e.g., page 1 of 2). The HHA retains the signed copy in its files.
9	Date	The physician enters the date he/she signed the addendum

**3.4 - MR of Skilled Nursing (SN) and Home Health Aide (AIDE) Hours for Determining Part-Time or Intermittent Care {tc \12 "3.4 -- Medical Review of Skilled Nursing and Home Health Aide Hours for Determining Part-Time or Intermittent Care }**

The RHHI requests medical documentation when it suspects that care is not part-time or intermittent care and makes decisions based on the documentation. They

- Request entrance and exit times of SN and aide visits;
- Review hours spent in the home in accordance with MIM §3119.7;
- For part-time care, approve medically necessary visits beginning before the 35th hour a week and before the 8th hour a day;
- For intermittent care, approve medically necessary visits beginning before the 35th hour of a week or approve medically necessary daily full-time care, up to and including 8 hours per day for finite and predictable periods. The 8 hours a day limit does not apply if the RHHI is approving less than daily care; and
- Do not make a decision that covered care could be accomplished in fewer hours if visits are determined to be covered and services are part-time or intermittent.

### **3.5 - Treatment Codes For Professional Services**

#### **3.5.1 - SN**

A1*	Skilled Observation and Assessment (Inc. V.S., Response to Med., etc.)	A2	Foley Insertion
A3	Bladder Instillation	A4*	Open Wound Care/Dressing
A5*	Decubitus Care (Partial tissue loss with signs of infection or full thickness tissue loss etc.)	A6*	Venipuncture
A7*	Restorative Nursing	A8	Post Cataract Care
A9	Bowel/Bladder Training	A10	Chest Physio (Inc. Postural drainage)
A11	Adm of Vitamin B/12	A12	Adm. Insulin
A13	Adm. Other IM/Subq	A14	Adm. IVs/Clysis
A15	Teach Ostomy or Ileo conduit care	A16	Teach Nasogastric Feeding

A17	Reinsertion Nasogastric	A18	Teach Gastrostomy Feeding
A19	Teach Parenteral Nutrition	A20	Teach Care of Trach
A21	Adm. Care of Trach	A22*	Teach Inhalation Rx
A23*	Adm. Inhalation Rx	A24	Teach Adm. of Injection
A25	Teach Diabetic Care	A26	Disimpaction/F.U. Enema
A27*	Other (Spec. under Orders)	A28*	Wound Care/Dressing - Closed Incision/Suture Line
A29*	Decubitus Care (Other than A5)	A30	Teaching Care of Any Indwelling Catheter
A31	Management and Evaluation of Patient Care Plan	A32*	Teaching and Training (other) (spec. under order)

\*Code which requires a more extensive descriptive narrative for physician's orders.

### **3.5.2 - Physical Therapy (PT){tc \I3 "3.5.2 -- Physical Therapy }**

B1	Evaluation	B2	Therapeutic Exercise
B3	Transfer Training	B4	Home Program Training
B5	Gait Devices	B6	Pulmonary Physical Therapy
B7	UltraSound	B8	Electrotherapy
B9	Prosthetic Training	B10	Fabrication Temporary
B11	Muscle Re-Education	B12	Management and Evaluation of a Patient Care Plan
B13	Reserved	B14	Reserved
B15	Other (Specify under orders)		

\*Code which requires a more extensive descriptive narrative for physician's orders.

### **3.5.3 - Speech Therapy (ST){tc \I3 "3.5.3 -- Speech Therapy }**

- |     |                               |    |                                   |
|-----|-------------------------------|----|-----------------------------------|
| C1  | Evaluation                    | C2 | Voice Disorders Treatments        |
| C3  | Speech Articulation Disorders | C4 | Dysphagia Treatments              |
| C5  | Language Disorders Treatments | C6 | Aural Rehabilitation              |
| C7  | Reserved                      | C8 | Non-oral Communication Treatments |
| C9* | Other (Specify under Orders)  |    |                                   |

\*Code which requires a more extensive descriptive narrative for physician's orders.

**3.5.4 - Occupational therapy (OT){tc \l3 "3.5.4 -- Occupational Therapy }**

- |      |                               |     |   |
|------|-------------------------------|-----|---|
| D1   | Evaluation                    | D2  | Independent Living/Daily Living Skills (ADL Training) |
| D3   | Muscle Re-education           | D4  | Reserved  |
| D5   | Perceptual Motor Training     | D6  | Fine Motor Coordination                               |
| D7   | Neuro-developmental Treatment | D8  | Sensory Treatment                                     |
| D9   | Orthotics/Splinting           | D10 | Adaptive Equipment (fabrication and training)         |
| D11* | Other (Specify Under Orders)  |     |   |

\*Code which requires a more extensive descriptive narrative for physician's orders.

**3.5.5 - Medical Social Services (MSS){tc \l3 "3.5.5 -- Medical Social Services}**

- |    |  |     |  |
|----|--|-----|--|
| E1 | Assessment of Social and Emotional Factors | E2  | Counseling for Long Range Planning and Decision Making |
| E3 | Community Resource Planning                | E4* | Short Term Therapy                                     |
| E5 | Reserved                                   | E6* | Other (Specify Under Orders)                           |

\*Code which requires a more extensive descriptive narrative for physician's orders.

### **3.5.6 - AIDE{tc \l3 "3.5.6 -- Home Health Aide }**

F1	Tub/Shower Bath	F2	Partial/Complete Bed Bath
F3	Reserved	F4	Personal Care
F5	Reserved	F6	Catheter Care
F7	Reserved	F8	Assist with Ambulation
F9	Reserved	F10	Exercises
F11	Prepare Meal	F12	Grocery Shop
F13	Wash Clothes	F14	Housekeeping
F15*	Other (Spec. under Orders)		

\*Code which requires a more extensive descriptive narrative for physician's orders.

### **3.5.7 - Acceptable V Codes{tc \l3 "3.5.7 -- Acceptable V Codes}**

V45.6	States following surgery of eye and adnexa
V45.81	Postsurgical status, aortocoronary bypass status
V45.89	Postsurgical status, presence of neuropacemaker or other electronic device
V46.0	Dependence on Aspirator
V46.1	Dependence on Respirator
V52.0	Fitting and adjustment of artificial arm
V52.1	Fitting and adjustment of artificial leg
V53.5	Fitting and adjustment ileostomy or other intestinal appliance
V53.6	Fitting and adjustment urinary devices

V54.0	Orthopedic aftercare involving removal of internal fixation device
V54.8	Orthopedic aftercare kirschner wire, plaster cast, external splint, external fixation device or traction device
V55.1	Attention to Gastrostomy
V55.2	Attention to Ileostomy
V55.3	Attention to Colostomy
V55.4	Attention to Other Artificial Opening of Urinary Tract
V55.5	Attention to cystostomy
V55.6	Attention to other artificial opening of urinary tract
V58.3	Attention to surgical dressing and sutures
V58.4	Other aftercare following surgery

### **3.6 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is “Confined to Home”**

**A. General Information.** RHHIs are instructed to do the following when a favorable final appellate decision that a beneficiary is “confined to home” is rendered on or after July 1, 2000.

**NOTE:** For the purposes of this manual section:

A favorable decision is a decision that is favorable to the beneficiary

A final appellate decision is a decision at any level of the appeals process where the RO has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.

- Promptly pay the claim that was the subject of the favorable final appellate decision.
- Promptly pay or review based on the review criteria below:
  - All claims that have been denied that are properly pending in any stage of the appeals process.
  - All claims that have been denied where the time to appeal has not lapsed.

- All future claims submitted for this beneficiary.
- For favorable final appellate decisions issued during a one-year grace period starting on July 1, 2000, and ending June 30, 2001, reopen all denied claims that are subject to the 12 month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.
- Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.
- Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.
- Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HCIN number, service date of the claim that received the favorable final appellate decision and the date of this decision. This information should be made available to HCFA upon request.

**B. Review Criteria.** Afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the beneficiary is confined to the home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision **unless** there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if (a) there has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home and (b) if the services provided meet all other criteria for home health care. If there have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review:

#### **EXAMPLE 1**

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight" in future medical review determinations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

#### **EXAMPLE 2**

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to the home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given “great weight,” with the result that the beneficiary would therefore be treated as “confined to the home” for subsequent medical review decisions. However, if upon review, evidence showed that the beneficiary's medical condition had changed and the ability to leave the home had improved then the favorable final appellate decision would no longer be given “great weight” in determining if the patient was “confined to home.” Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the beneficiary’s ability to leave the home.

#### **4 - MR of CORF Claims {tc \l1 "4 -- MR of Comprehensive Outpatient Rehabilitation Facility (CORF) Claims }**

CORF services are an expansion of the scope of benefits under Medicare Part B which enable beneficiaries to receive coordinated comprehensive outpatient rehabilitation services at one fixed location.

The purpose of intermediary MR is to assure that payment is made only for covered care as described in MIM §§3180ff. and that it neither exceeds the medical needs of the patient nor represents a non-covered level of care (e.g., maintenance therapy).

##### **4.1 - Review of CORF Claims {tc \l2 "4.1 -- Review of CORF Claims }**

Intermediaries analyze the data available for CORF providers and services as part of the intermediary FMR effort. (See PIM Chapter 2, §2.1.) They focus on aberrant practices to select claims for MR, such as the providers which have been identified as billing for non-covered care, services frequently determined to be non-covered or other criteria that identifies potentially non-covered care. Intermediaries determine the level of review based on their data analysis.

##### **4.2 - Purpose of the MR{tc \l2 "4.2 -- Purpose of the MR.}**

Generally, services provided by the CORF must be furnished onsite under a written plan of treatment, except for one nonmandatory home evaluation visit. Effective December 22, 1987, PT, OT, and speech pathology services may be furnished off-site. (See MIM §3182.) Such services may be covered if furnished pursuant to the plan of treatment, and if they do not duplicate services for which payment has otherwise been made under Medicare.

Intermediaries must assure that the CORF services provided were:

- Covered services as described in MIM §§3181 and 3183;
- Furnished to a patient who is under the care of a physician and was referred by the physician certifying that the individual needs skilled rehabilitation services;
- Stipulated in a written plan of treatment that is established and signed by a physician before treatment began;

- Stipulated in a written plan of treatment that prescribes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated specific rehabilitation goals; and
- Reasonable and necessary in relation to the patient's rehabilitation potential and progress.

A CORF physician must review the plan of treatment every 60 days. The reviewing physician must certify/recertify the following:

- That the plan is being followed;
- The patient is making progress in attaining the rehabilitation goals; and
- The treatment is having no harmful effects.

Normally, the plan of treatment and certification/recertification are coordinated and contained in one document.

**NOTE:** Where a signed copy of the plan of treatment is not being required for review and/or the certification/re-certification statement and physician signature is not on the same document as the plan of treatment, this information must be retained in the CORF files and be available upon request.

#### **4.3 - Documentation Requirements{tc \l2 "4.3 -- Documentation Requirements }**

CORF services are paid only if they meet all requirements established by Medicare guidelines and regulations. Intermediaries conduct FMR of CORF claims. Billing and utilization data is analyzed and the review is focused to those claims, services, or providers where there is the greatest risk of inappropriate program payment. Each bill for CORF services subjected to MR must be supported with adequate medical documentation. These are payable CORF services. Intermediaries request documentation if and when it is required to have medical information with the claim. Intermediaries must also inform providers as to the reason for requesting the medical information.

Intermediaries must request, at a minimum, the documentation outlined below for MR of CORF claims. They may request that the information be entered on a medical information form designed to elicit this information, or that copies of the information be supplied from the medical record. They use the general guidance outlined below, as well as the specific documentation requirements in PIM Chapter 6, §§5ff, 6ff and 7ff.

Examples of intermediary solicited information include:

- \$ A written plan of treatment--signed by the physician including the information in the Outpatient Manual §500.A., or the information from the plan of treatment provided on a form approved by the intermediary.

**NOTE:** Where a signed copy of the plan of treatment is not submitted, or the certification/recertification statement and physician signature is not on the same document as the plan of treatment, providers must retain the required information and signatures in the files to be available upon request.

- § Pertinent medical history which includes the date of onset or exacerbation of the condition for which services are being furnished; results of prior rehabilitation treatment (if any) for the same condition; and functional capability prior to current start of care.
- A description of functional limitations and rehabilitation potential;
  - The results of initial evaluations by the CORF;
  - Progress report and re-evaluation which must include a description of the treatment furnished; a description of the results of both subjective and objective tests and measures as compared to the initial or prior evaluation results; and a description of the progress the patient is making toward obtaining the rehabilitation goals.

**NOTE:** For situations where treatment is to be continued however, no progress is being made, a statement by the physician as to why treatment should be continued must be included.

#### **A - Documentation Required with the Initial Bill and Every 60 Days Thereafter**

Intermediaries request a written plan of treatment signed by the physician which includes either the information specified in subsection C, or information from the plan of treatment provided it is transcribed on a medical information form.

#### **B - Documentation Required with the Initial Bill**

Intermediaries request pertinent medical history including the date of onset or exacerbation of the condition for which the services are being rendered, the results of prior rehabilitation services (if any) for the same condition, description of functional limitations and rehabilitation potential, and the results of the initial evaluation by the CORF.

#### **C - Documentation Required with Subsequent Claims**

Intermediaries request the progress report and reevaluation findings which must reflect:

- A description of the treatment rendered;
- A description of the progress the patient is making toward attaining the rehabilitation goals, and the results of both subjective and objective tests and measures as compared to the initial or prior evaluation results; and

- A statement by the physician of why treatment should be continued if progress is not being made.

**NOTE:** Daily notes are not required. A summary of progress or non-progress must be documented with each billing.

**4.4 - Mental Health Services Limitation**

The amount of a beneficiary's incurred mental health expenses that can be recognized in any calendar year is the lesser of 62.2 percent of expenses or the amount shown in the following table:

Year of Service	Limit Recognized	Payment Limit
Through 12/31/87	\$312.50	\$250.00
1/1/88 - 12/31/88	\$562.50	\$450.00
1/1/89 - 12/31/89	\$1,375.00	\$1,100.00

Effective January 1, 1990, no dollar limit is applied, only a 62.5 percent limit on a beneficiary's incurred mental health expenses will be recognized in a calendar year.

In determining when the limitation applies, intermediaries must separate the charges for the psychotherapeutic aspects of the treatment from the non-psychiatric aspects. When they are not readily distinguishable, intermediaries allocate the charges as follows:

- Psychological services, whether furnished by psychologists or other personnel, are always subject to the limitation regardless of the patient's diagnosis;
- PT, respiratory therapy, ST and services furnished in connection with prosthetic and orthotic devices and the use of equipment and appliances related to these services are not subject to the limitation; and
- For services not specified above, such as OT, determine the primary reason for the patient being referred to the CORF. If the referral is primarily on the basis of a psychiatric condition, all services are subject to the limitation.

If the referral is primarily on the basis of a diagnosis of Alzheimer's Disease (coded 331.0 in the International Classification of Diseases, 9th Revision) or Alzheimer's or other disorders coded 290.XX in the American Psychiatric Association's Diagnosis and Statistical Manual - Mental Disorders, such services typically represent management of the patient's condition (rather than psychotherapy) and **are not** subjected to the benefit limitation. Where a particular service provided a patient with such a diagnosis is primarily for psychological services as specified above, it is subject to the limitation.

If the referral is primarily on the basis of a physical condition, the services are not subject to this limitation. If the primary reason for referral is not clear, 50 percent of the customary charges is subject to the limitation.

## **5 - MR of Part B Intermediary Outpatient Physical Therapy (OPT) Bills{tc \l1 "5 -- MR of Part B Intermediary OPT Bills }**

These instructions specify the criteria for MR of OPT services. Intermediaries shall use the edits listed in PIM Chapter 6, §5.4.1 to assist in conducting focused review within budgeted levels. They may conduct MR using other selection criteria determined to be effective. If an intermediary chooses to use any of the diagnostic edits listed in PIM Chapter 6, §5.4.1, the visits and/or duration parameters may not be changed without approval from CO. They conform to the MR requirements for all outpatient claims from rehabilitation agencies, SNFs, hospitals, and HHAs that provide OPT in addition to home health services.

### **A B Bill Review**

The bill types are:

- Hospital = 12X and 13X;
- SNF = 22X and 23X;
- HHA = 34X;
- Rehabilitation agency, public health agency or clinic = 74X; and
- CORF = 75X

These criteria do not apply to PT services provided under a home health plan of care.

Intermediaries evaluate bills based upon the following data that providers must submit on the bill:

- Facility and Patient Identification--Patient name, provider number, HICN, age;
- Diagnosis--List, by ICD-9-CM code, the primary diagnosis for which OPT services were first furnished. Follow with other Dx(s) (diagnoses), applicable to the patient or that influence care;
- Duration--Include the total length of time the provider furnished OPT services (in days) from the date treatment was initiated for the diagnosis (including the last day in the current billing period);
- Number of Visits--Include the total number of patient visits completed since OPT services were initiated for the diagnosis being treated. The provider must enter the total

number of visits to date (including the last visit in the billing period) rather than for each separate billing (value code 50);

- Date of Onset (Occurrence Code 11)--The date of onset of the primary PT diagnosis for which the provider furnished OPT services;
- Date Treatment Started (Occurrence Code 35)--Include the date services were initiated for the primary PT Dx being treated; and
- Billing Period--When OPT services began and ended in the billing period ("FROM/THROUGH" dates).

The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits. See PIM Chapter 6, §5.4.1. **Intermediaries do not deny a bill solely on the basis that it exceeds the criteria in these edits.** The edits are **only** for assisting the intermediary in selecting bills for MR or for paying bills that meet Level I. Also, intermediaries do not provide automatic coverage up to these criteria. They neither guarantee minimum coverage nor set maximum coverage limits.

### 5.1 - Level I Review{tc \l2 "5.1 -- Level I Review}

PT edits have been developed for a number of diagnoses. The diagnoses were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with those diagnoses will require skilled OPT. The edits do not specify every diagnosis that may require PT, and the fact that a given diagnosis does not appear in the edits does not create a presumption that OPT services are not necessary or are inappropriate. Intermediaries do not approve or deny claims at Level I for reasonable and necessary. They pay claims that suspend or pass the edits in PIM Chapter 6, §5.4.1 without being subjected to Level II MR. However, they refer all claims that meet the intermediary MR criteria to Level II MR.

For patients receiving other PT services (V57.1) only during an encounter/visit, the appropriate V code for the service is listed first, and, if documented, the diagnosis or problem for which the services are being performed second. The intermediary standard system must program the system to read the diagnosis or problem listed second to determine if it meets one of the Level I edits.

**EXAMPLE:** Outpatient rehabilitation services, V57.1 (Other PT), for a patient with multiple sclerosis, 340. The V code is listed first, followed by the code for multiple sclerosis (V57.1, 340). Intermediaries must edit for multiple sclerosis not the V code.) They use this same procedure for V57.81 (Orthotic training), V57.89 (Other specified rehabilitation procedure), and V57.9 (Unspecified rehabilitation procedure).

Evaluate bills at Level I based upon each of the following:

Facility and Patient  
Identification

Facility name, patient name, provider number, HICN, age

Diagnosis	List the primary diagnosis for which OPT services were furnished by ICD-9-CM code first. List other Dx(s) applicable to the patient or that influence care next.
Duration	The total length of time OPT services have been rendered (in days) from the date treatment was initiated for the diagnosis being treated at the billing provider (including the last day in the current billing period).
Number of Visits	The total number of patient visits completed since OPT services were initiated for the diagnosis being treated by the billing provider. Enter the total number of visits to date (including the last visit in the billing period) rather than for each separate billing (value code 50).
Date Treatment Started (Occurrence Code 35)	The date OPT services were initiated by the billing provider for the primary PT Dx being treated.
Billing Period	When OPT services began and ended in the billing period (from through dates).

## **5.2 - Level II Review Process{tc \12 "5.2 -- Level II Review Process}**

If a bill is selected for MR, intermediaries refer it to the Level II health professional MR staff. If possible, they have physical therapists review OPT bills. Once the bill is selected for MR, they review the bill in conjunction with medical information submitted by the provider. They use this criteria to perform MR of OPT claims for the bill types identified in PIM Chapter 6, §5ff.

### **A - Payable OPT Services**

Intermediaries pay OPT services only if the services meet all requirements established by Medicare guidelines and regulations. They ensure that each bill subjected to Level II or III MR is supported with adequate medical documentation to make a determination. The documentation must show that the requirements of MIM §§3101.8 and 3148, and in these instructions, are met.

## **5.3 - MR Documentation for OPT Bills {tc \12 "5.3 -- MR Documentation for OPT Bills }**

An intermediary may also select a bill for intensified review. When a bill is selected for this type of review, they review the bill in conjunction with the medical information submitted. When additional medical information is needed, they may request the data identified below.

When a claim is referred to Level II MR, intermediaries must use the following pertinent data elements in addition to those used for Level I review.

Medical History	Obtain only the medical history which is pertinent to, or
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influences the OPT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring OPT, and any pertinent prior PT treatment.

Date of Onset (Occurrence Code 11) The date of onset of the primary physical therapy diagnosis for which OPT services were being rendered by the billing provider.

Physician Referral and Date

PT Initial Evaluation and Date

Plan of Treatment and Date Established

Date of Last Certification Obtain the date on which the plan of treatment was last certified by the physician.

Progress Notes Obtain updated patient status reports concerning the patient's current functional abilities/limitations.

Intermediaries must use the above information along with that in PIM Chapter 6 §5.1, to assess the appropriateness of the OPT plan of treatment and the patient's progress relative to diagnosis, date of onset, etc. The medical information supporting a bill must be specific. Documentation written in general terms, e.g, "strength appears to have increased" or "can now reach higher overhead" or "medical history-chronic arthritis" is insufficient. To make an informed MR decision request documentation from the provider when incomplete or inadequate documentation is present. The physician's pertinent evaluations, progress notes and opinions about the patient's need for rehabilitation services should also be used (when these are available). Obtain this information from the provider regardless of the document type the provider keeps (i.e., it does not matter whether the baseline evaluation is part of the treatment plan, the progress notes or the medical history, obtain and use this information).

### **5.3.1 - Medical History {tc \13 "5.3.1 -- Medical History }**

Medical history is information that is pertinent to, or that influences, the OPT treatment furnished. This may include prior history and treatment by the referring physician, when available. If a history of previous OPT treatment is not available, the provider may provide a general summary regarding the patient's past relevant medical history recorded during the initial evaluation with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior history and treatment by the referring physician must be provided when available.

The patient's medical history, as it relates to the OPT, must include the date of onset and/or exacerbation of the illness or injury. If the patient has had prior OPT for the same condition, intermediaries use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is also necessary for patients who have transferred to a new provider for additional treatment. For example, if surgery has been performed, intermediaries should be aware of the type and date of surgery. The date of onset and type of surgical procedure should be specific for diagnoses such as fractured hip. For other diagnoses, such as arthritis, the date of onset may be general and can be established from the date the patient first required medical treatment. For other types of chronic diagnoses, the history must give the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OPT. For example, a patient that had an amputation several years ago might recently have been fitted with a new prosthesis.

### **5.3.2 - Evaluation**

Intermediaries should approve a PT initial evaluation, (excluding routine screening) when it is reasonable and necessary for the therapist to determine if there is an expectation that either restorative or maintenance services will be appropriate for the patient's condition. They approve reevaluations when the patient exhibits a demonstrable change in physical functional ability in order to reestablish appropriate treatment goals, or when required for ongoing assessment of the patient's rehabilitation needs. Initial evaluations or reevaluations that are determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The PT evaluation establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's condition must form the basis for the physical therapy treatment goals.

The evaluation must (when possible) include objective tests and measurements which normally will include functional, strength, and range of motion (ROM) assessments. However, for patients with certain neurological conditions (such as upper motor neuron conditions) assessment of strength may not be valid. Where the above tests are not applicable, the physical therapist should document the patient's functional loss and the need for skilled OPT intervention resulting from conditions listed below.

#### **A - Self-Care Dependence**

The individual is dependent upon skilled assistance or supervision from another person in self-care activities. These activities include, but are not limited to, significant functional loss or loss of previous functional gains in the ability to:

- Drink;
- Feed;

- Dress; or
- Maintain personal hygiene.

Additionally, this could include care of braces or other adaptive devices.

### **B - Mobility Dependence**

The individual is dependent upon another person for skilled OPT assistance or supervision in such areas as transfer, gait training, stair climbing, and wheelchair maneuvering activities due to, but not limited to:

- Decreased strength;
- Marked muscle spasticity;
- Moderate to severe pain;
- Contractures;
- Loss of coordination;
- Perceptual motor loss;
- Orthotic need; or
- Need for ambulatory or mobility device.

This could involve patients with or without impairment of the lower leg who are partially independent with wheelchair and/or who have significant architectural or environmental barriers.

### **C - Safety Dependence/Secondary Complications**

A safety problem exists when a patient without skilled assistance cannot handle him/herself in a manner that is physically safe. This may extend to the performance of activities of daily living or to acquired secondary complications that could potentially intensify medical sequelae such as fracture nonunion, or decubiti. Some examples of safety dependence may be demonstrated by high probability of falling, swallowing difficulties, severe pain, loss of skin sensation, progressive joint contracture, and infection requiring skilled PT intervention to protect the patient from further complication.

Each patient's condition calls for assessments which are unique to specific impairments. For example, documentation in the treatment of open wounds or ulcerations require other objective and subjective documentation, such as size and depth of the wound, amount and frequency of drainage, signs of granulation, or evidence of infection, etc.

If the goal for any patient is to increase functional abilities, range of motion, or strength, the initial evaluation must measure (if possible) the patient's starting functional abilities, range of

motion and strength. If the assessment indicates that joint range of motion or strength is normal, there should be evidence of this assessment in the initial evaluation or progress notes, e.g., "within normal limits." If objective documentation cannot be accomplished for any reason, this should be noted in the initial evaluation or progress notes along with the reason(s).

### **5.3.3 B Plan of Treatment {tc \13 "5.3.3 B Plan of Treatment }**

The PT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The plan of treatment must include specific modalities/procedures, frequency, and duration of treatment. Changes in the plan of treatment should be submitted with the progress notes.

The plan of treatment must contain the following information concerning the OPT treatment:

Type of Modalities/Procedures	Should describe the specific nature of the therapy to be provided. Some examples of PT modalities/procedures are deep heat (e.g., diathermy, ultrasound), superficial heat (e.g., hot packs, whirlpool), and therapeutic exercises and gait training.
Frequency of Visits	An estimate of the frequency of treatment to be rendered (e.g., 3x week).
Estimated Duration	Identifies the length of time over which the services are to be rendered and may be expressed in days, weeks, or months.
Diagnoses	Should include the OPT diagnosis if different from the medical diagnosis. For example, the medical diagnosis might be "rheumatoid arthritis." However, the shoulder might be the only area being treated, so the PT diagnosis might be "adhesive capsulitis." In order to establish the OPT diagnosis, diagnostic tests must be used whenever possible.
Functional Goals	Should reflect the physical therapist's and/or physician's description of what the patient is expected to achieve as a result of therapy.
Rehabilitation Potential	The therapist's and/or physician's expectation concerning the patient's ability to meet the goals at initiation of treatment.

### **5.3.4 - Progress Reports {tc \13 "5.3.4 -- Progress Reports }**

The physical therapist must provide treatment information regarding the current status of the patient during the course of the billing period. The PT progress notes or status summary related to the billing period and any needed reevaluation(s) must update the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, it must be

documented in accordance with MIM §3148.3. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect comparison between the patient's current functional status and that obtained during the previous billing and/or at the initial evaluation.

Where a valid expectation of improvement exists at the time OPT services are initiated, or thereafter, reasonable and necessary services would be covered even though the expectation may not be realized. However, in such instances, the OPT services are covered only up to the point in time that no further significant functional improvement can be reasonably expected. Progress reports or status summaries by the physician and/or physical therapist must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time. "Significant," in this context, means a generally measurable and substantial increase in the patient's present level of physical functional abilities compared to their level at the time treatment was initiated.

Intermediaries should not interpret the term "significant" so stringently that a claim is denied simply because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer should approve the claim if the services are considered reasonable and necessary and if there is still a reasonable expectation that significant improvement in the patient's **overall safety or functional ability** will occur. However, the physical therapist and/or physician should document such lack of progress and briefly explain the need for continued skilled PT intervention.

MR of rehabilitation claims must be conducted with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is **not** possible. For example, a terminally ill patient may begin to exhibit self care, mobility and/or safety dependence requiring PT services. The fact that full or partial recovery is not possible or rehabilitation potential is not present, must not affect MR coverage decisions. The deciding factor is always based on whether the services are considered reasonable, effective, treatment for the patient's condition and they require the skills of a physical therapist, or whether they can be safely and effectively carried out by non-skilled personnel, without PT supervision. The reasons for PT intervention must be clear to the reviewer, as well as their goals, prior to a coverage determination. These claims often require review at Level III.

It is essential that the physical therapist document the updated status in a clear, concise, and objective manner. Objective tests and measurements are stressed when these are practical. The physical therapist selects the appropriate method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used to demonstrate progress is changed or comparable measures are used; the reasons for the change should be documented, including how the new method relates to the old. The MR staff must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

While objective documentation often supports ROM, strength, and other objective measurements; documentation of the patient's current functional status compared to previous reporting period(s) is of paramount importance. The deficits in functional ability should be clear.

Physical therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated whenever possible in objective, measurable terms. The following illustrates these principles:

### **A - Pain**

Documentation describing the presence or absence of pain and its effect on the patient's functional abilities must be considered in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion will materially aid correct MR decisions. Documentation should describe the limitations placed upon the patient's self care, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

Transcutaneous electrical nerve stimulation (TENS) uses surface electrodes and electrical current to interrupt pain pathways and sensation of pain through peripheral nerves. Generally, it is covered on a trial basis for up to 1 month. Any trial period extending beyond 1 month must be documented as to reason and medical necessity. Intermediaries approve such claims only when the documentation supports the need to assess the patient's suitability for continued treatment with TENS. When it is determined that TENS should be continued as therapy and the patient has been trained to use the stimulator, it is expected that the stimulator will be employed by the patient at home. Payment may be made under the prosthetic devices benefit for the TENS stimulator. Payment may not be approved for continued OPT treatments with TENS. (See Coverage Issues Manual 35-46 and 65-8.)

### **B - Therapeutic Exercise**

The objective documentation should support the skilled nature of the exercise program, and/or the need for design and establishment of a maintenance exercise program. The goals should be to increase functional abilities in self care, mobility, or patient safety. Documentation should indicate the goals and type of exercise provided and the major muscle groups treated.

Intermediaries approve claims when the therapeutic exercise, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by, or under, the supervision of a physical therapist. For example, while passive and active assistive exercise may often be performed safely and effectively by non-skilled personnel, the presence of fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled PT intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or physical therapy notes. To make correct MR decisions, the patient's losses and/or dependencies in self care, mobility and safety must also be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support why skilled PT is needed for the patient's medical condition and/or safety.

Intermediaries approve establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions supportive personnel and/or family members need to safely and effectively carry out the program. Reevaluation may be approved

when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be adequate justification for readjusting a maintenance program, e.g., loss of previous functional gain.

### **C - Cardiac Rehabilitation Exercise**

PT is not covered when furnished in connection with cardiac rehabilitation exercise program services unless there also is a diagnosed non-cardiac condition requiring it, e.g., where a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires PT. (See Coverage Issues Manual §35-25.) While the cardiac rehabilitation exercise program may be considered by some a form of PT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are formed under the direct supervision of a physician. Restrictions on PT coverage do not affect rules regarding coverage or non-coverage of such services when furnished in a hospital inpatient or outpatient setting.

### **D - Gait Training**

The documentation must support the need for skilled gait training to restore functional abilities (or to design and establish a safe maintenance program) which can reasonably be expected to improve the patient's ability to walk or walk more safely. Documentation should clarify the patient's gait deviation, current functional abilities and limitations, and/or safety dependence during gait. Documentation should identify the gait problem being treated, e.g., to correct a balance/incoordination and safety problem or a specific gait deviation, such as a Trendelenberg gait. The type of gait deviation requiring skilled intervention, the functional limitations in mobility, the patient's understanding or lack of understanding of the gait training, and the amount of assistance needed during training is needed to make correct review decisions. The documentation must differentiate skilled gait training rendered from assistive walking, when the patient is walking repetitiously and merely improving distance or endurance (assistive or non-assistive).

### **E - Transfer Training**

The documentation should describe the patient's functional limitations in transfer ability that warrant skilled PT intervention. Documentation should include the special transfer training needed and rendered, and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Intermediaries approve transfer training when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the task.

Documentation that supports only repetitious carrying out of the transfer method, once established, and monitored for safety and completion of the task is non-covered care.

### **F - Electrical Nerve Stimulation**

Intermediaries approve reasonable and necessary electrical stimulation to delay or prevent disuse atrophy, but only where the documentation indicates that the nerve supply (including brain,

spinal cord and peripheral nerves) to the muscle is intact, and other non-neurological reasons for disuse are causing atrophy. (See Coverage Issues Manual §35-77.)

Electrotherapy for the treatment of facial nerve paralysis, e.g., Bell's palsy is not a covered service. (See Coverage Issues Manual §35-72.)

Intermediaries approve functional electrical stimulation (FES) used to test the suitability for improving the patient's functional ability, e.g., stimulating the dorsiflexors of the ankle to reduce toe drag during the swing-through phase of gait. Documentation must indicate the patient's functional limitation.

### **G - Biofeedback Therapy**

Intermediaries approve claims when the documentation indicates that biofeedback therapy is reasonable and necessary for the patient for muscle reeducation of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Intermediaries deny claims where the documentation supports treatment for ordinary muscle tension states or for psychosomatic conditions. (See Coverage Issues Manual 35-27.)

### **H - Fabrication of Temporary Prostheses, Braces, and Splints**

Intermediaries approve reasonable and necessary fabrication of temporary prostheses, braces and splints, and any reasonable and necessary skilled training needed in their safe and effective use. The documentation must indicate the need for the device and training.

### **5.3.5 - Certification and Re-certification**

To meet Medicare guidelines, PT services must be certified and re-certified by a physician. They must be furnished while the patient is under the care of a physician. The OPT services may be furnished under a written plan of treatment established by the physician or a qualified physical therapist providing them; however, if the plan is established by a physical therapist, it must be reviewed periodically by the physician.

The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When OPT services are continued under the same plan of treatment for a period of time, the physician must certify at least every 30 days that there is a continuing need for them. Obtain the re-certification at the time the plan of treatment is reviewed since the same 30 day interval is required for the plan's review.

Any changes to the treatment plan established by a physical therapist must be in writing and signed by the physical therapist or by the attending physician. Re-certifications must be signed by the physician who reviewed the plan of treatment. The physician may change a plan of treatment established by the physical therapist, but the physical therapist may not alter a plan of treatment established by a physician.

### 5.3.6 - PT Forms {tc \13 "5.3.6 -- Physical Therapy Forms }

Documentation may be submitted on a specific form or copies of the provider's record. Intermediaries require a specific form if they find it more efficient than using provider records; however, it must capture the MR information required by these instructions. If the intermediary chooses to require a form, it must display the OMB clearance number on each form. The information must be complete. If it is not, they request the missing information and return the bill for the additional information. The information the intermediary requires to review the bill is that required by a physical therapist to properly treat a patient.

### 5.3.7 B Post-Pay Sample -Denial Rate{tc \13 "5.3.7 B Post-Pay Sample -Denial Rate }

Intermediaries review a random sample of the bills that pass all edits.

Intermediaries conduct a post-pay MR on each claim selected in the random sample. This random sample determines a hospice denial rate by combining the prepay and postpay denials for the same quarter. The rate is calculated by dividing the total charges that the intermediary has determined noncovered by the total charges submitted by the hospice in that quarter. Providers having a 5 percent or higher denial rate in any quarter are placed on 100 percent prepay MR in the subsequent quarter. Providers with a denial rate of less than 5 percent for two (2) consecutive quarters may be removed from 100 percent MR. New providers are handled according to the intermediary's existing procedures.

The intermediary may also investigate abnormal trends uncovered during the random post-pay sample review. The intermediary must alert the RO to the review findings, along with recommendations for corrective actions.

### 5.4 - Evaluation of PT Edits{tc \12 "5.4 -- Evaluation of PT Edits }

Intermediaries must perform regular evaluations of provider utilization of PT services if they are using the HCFA edits to assist in identifying PT claims for focused MR. They change focused review claims selection based on the results of the evaluation. For example, a provider consistently billing at an aberrant rate just below the edit parameters or providers billing abnormally high utilization for specific diagnostic codes may be subject to focused review.

#### 5.4.1 B OPT Edits {tc \13 "5.4.1 B Outpatient Physical Therapy Edits }

The following edits do **not** represent normative (or average) treatment. It is prohibited to deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

<u>Edit Identification Number</u>	<u>Diagnosis</u>	<u>ICD-9-CM</u>	<u>Number Of Visits</u>	<u>Duration (Days)</u>
1	Neoplasms	162.0-163.9 185-188.9	13 16	38 48

		165.0-165.9		
		171.0-172.9		
		173.5-173.9		
		174.0-175.9		
		191.0-192.9		
		195.3-195.8		
		201.00-208.9		
		237.5-237.9		
		238.0-238.1		
		239.1-239.3		
		239.8-239.9	24	62
		170.2-170.9		
		225.0-225.9		
		239.6		
2	Parkinson's Disease	332.0-332.1	13	38
3	Meningitis/Encephalitis	320.0-323.9	16	62
	Intracranial and Intraspidal Abscess	324.0-324.9		
	Other Extrapryramidal Disease	333.0		
	Hydrocephalus and Other Cerebral Degeneration	331.3-331.4		
	Huntington's Chorea and Other Choreas	331.89		
	Spinocerebellar Disease	333.4-333.99		
	ALS and Other Motor Neuron Diseases	334.0-334.9		
	other diseases of the spinal cord	335.2-335.9		
	Unspecified disorder of autonomic N.S.			
	Multiple Sclerosis	336.0-336.9		
	Demyelinating Diseases of CNS	337.9		
	Hemiplegia (old unspecified)			
	Cerebral palsy	340		
	Late effects of CVA	341.8-341.9		
	Other conditions of brain	342.0-342.9		
	Other unspecified disorders of nervous System	343.0-343.9		
		438		
	Other ill defined cerebrovascular diseases	348.0-348.9		
	Intracranial injury	349.0-349.9		
		437.0-437.9		
		851.00-854.19		
4	Cerebral hemorrhage, occlusion, stenosis	430-434.9	28	72
	CVA, acute			
	Concussion, Loss of consciousness without return to previous level	436		
	Intracranial injury including those	850.40-850.49		

	with skull FX	800.70-800.89 801.70-801.89 803.20-803.39 803.70-803.89 804.70-804.89		
5	Othre paralytic syndromes, paraplegia Quadriplegia	344.0-344.9	32	93
6	Post-herpetic polyneuropathy	053.13	13	40
	Neurosyphilis	094.0-094.9		
	Late effects polio	138		
	Disorders of peripheral nerves	353.0-359.9 (except 357.0)	16	62
	Fx of vertebral clumn with spinal cord Injury	806.00-806.5 806.8-806.9	30	93
	Spinal cord injury without spinal bone injury. Peripheral nerve injury.	952.00-957.9	24	62
	Acute infective polyneuritis	357.0		
	Disturbance of skin sensation	782.0	12	38
	Bell's plasy	351.0		
	Injury to facial nerve	951.4		
7	Diabetes with peripheral circulatory Disorders	250.00-250.01 250.60-250.71	16	62
	Aortic aneurysm	441.4-441.9 442.9		
	Arterial embolism	444.0-446.5		
	Hypertension unspecified	401.9-402.00	13	38
	Diseases of circulatory system	429.9		
	Raynaud's/Buerger's/PVD	443.0-443.9		
	Thrombophlebitis lower extremity	451.11-451.2 451.9		
	Other diseases of arteries and arterioles	453.8-453.9		
	Other disorders of circulatory system	447.0-447.9		
	Edema	459.0-459.9 782.3	10	31
	Postmastectomy lymphedema other lymphedema	457.0-457.1		
	Varicose vein with inflammation	454.1		
8	Chronic ulcer of skin	707.0-707.9	29	62
	Hansen's Disease	030.0-030.9	25	62
	Gas gangrene	040.0		
	Diabetes with ulcer manifestation	250.80-250.81		
	Varicose vein with ulcer	454.0		

		454.2		
	Cellulitis	681.00-682.9		
		686.0-686.9		
	Other local infection of skin	785.4		
	Gangrene	875.0-884.2		
	Open wounds	890.0-894.2		
		941.20-941.29		
	Burns (second degree)	942.20-942.29		
		943.20-943.29		
		944.20-944.28		
		945.20-945.20		
		946.2		
		949.2		
		958.3		
	Post traumatic wound infection	915.9, 916.9	13	31
	Superficial injury infected	917.9, 919.9		
9	Psoriasis	696.0-696.1	14	62
	Dermatitis unspecified	692.9	13	31
	Unspecified disorder of skin	709.9		
10	Acute Bronchitis	466.0-466.1	12	31
	Bronchopneumonia	480.0-486		
	Bronchitis, emphysema	490-492.8		
	Chronic airway obstruction	496		
	Symptoms of respiratory system and other chest symptoms	786.09	9	31
	Tuberculosis respiratory Asthma unspecified	786.50, 786.52		
	Bronchiectasis	010.00-012.8		
		493.9, 494		
11	Chronic renal failure	585	12	38
	Acute renal failure	584.9		
	Nephritis, nephropathy	583.9		
	Renal failure unspecified	586		
	Unspecified lesion in kidney	593.9		
12	Lupus erythematosus	695.4	16	62
	Diffuse disease of connective tissue	710.0-710.9		
	Arthropathy associated with infection	711.00-711.99		
	Arthropathy associated with other Disorders	71.0-713.8		
	Rheumatoid arthritis and Inflammatory polyarthropathies	714.0-714.9		
	Gouty arthropathy	274.0		
13	Osteoarthrosis and allied disorders	715.00-716.99	13	31

14	T.M.J. disorders Internal derangement of joint, other Derangement of joint and other Unspecified disorders of joint	524.6 717.0-719.99	13	38
15	Dorsopathies Ostetis deformans Aseptic necrosis Disorder of bone and cartilage Chondromalacia Other acquired deformities  Anomalies of spine	720.0-724.9 731.0 733.40-733.49 733.81-733.91 733.92 733.99 737.0-737.9 738.4-738.6 738.8-738.9 756.10-756.12 756.19, 756.9	13	31
	Osteomyelitis Acquired deformities	730.00-730.29 736.00-736.9 755.31	16	62
	Osteoporosis Pathological Fx	733.00-733.09 733.1	10 12	31 31
16	Peripheral enthesopathies and allied Syndromes  Disorders of muscles, tendons and their Attachments and other soft tissues Herpes zoster	725-729.9 (excluding 727.1 and 727.40-727.49)  053.10-053.12 053.8-053.9	13	31
17	Senile dementia Other cerebral degenerations  Nonallopathic lesions Gait disturbance due to debility Syncope/collapse convulsions, dizziness Abnormal posture Debility, unspecified and other Abnormal Involuntary movements  Abnormality of gait incoordination Transient paralysis of limb T.I.A.	290.0-290.10 331.0-331.3 331.9 739.1-739.7 780.7 780.2-780.4  781.9 799.3 799.8-799.9  781.0 781.2-781.4	10	31
			12	38

		435.0-435.9	13	38
18	Fx of vertebral column without cord Injury	805.00-805.98	13	38
	Fx of rib, sternum	807.00-807.49	12	38
	Fx of clavicle	810.00-810.03		
	Fx of unspecified bone	829.0-829.1		
19	Fx of pelvis	808.0-808.9	18	62
	Fx of femur	820.0-821.39		
20	Fx of patella	822.0-822.1	18	62
	Fx of tibia and fibula	823.00-823.92		
	Fx of ankle, tarsals, metatarsals	824.0-825.39	13	62
	Fx, other multiple	827.0-82.1		
21	Fx of humerus, F of radius and ulna, Fx of carpals, Fx of metacarpals and Phalanges	811.00-819.1	18	62
22	Dislocations	830.0-839.9	18	62
	Crushing injury	927.0-929.9		
23	Sprains and strains	840.0-848.9	13	31
	Late effects of strains, sprains	905.6-905.7		
	Dislocation			
	Contusions	922.0-924.9		
	Injury, other unspecified	959.0-959.9		
24	Amputation upper	885.0-887.7	24	62
	Lower	895.0-897.7	28	93
25	Burns (3 <sup>rd</sup> and 4 <sup>th</sup> degree)	941.30-941.59 942.30-942.59 943.30-943.59 944.30-944.58 945.30-945.59 946.3-946.5 949.3-949.5	32	93
26	Joint replacement	V43.6	13	38
	Aortocornary bypass	V45.81		
	Neuropacemaker	V45.89		
	Convalescence following FX	V66.4		
	Followup exam FX	V67.4		
	Fitting and adjustment of prosthetic care	V52.0-52.1	10	31
	Removal internal fixation device			

Observation for specified condition	V54.0		
Orthopedic aftercare	V71.8		
Other aftercare following surgery	V54.8-V54.9	12	38
Other specified aftercare	V58.4		
Unspecified aftercare	V58.8		
Other followup	V58.9		
	V67.59, V67.9		
Late effects Fx	905.1-905.5		
Late effects tendon injury	905.8	13	38
Late effects amputatoin	905.9		
Late effects of injuries	906.0-909.9		
Complications of surgical and medical Care	996.4		
	996.60-997.3		
	997.60-997.9		
	998.3, 998.5		
	998.8-998.9		
	999.9		

**6 - MR of Part B Intermediary Outpatient Speech-Language Pathology (SLP) Bills{tc \11 "6 -- MR of Part B Intermediary Outpatient Speech-Language Pathology (SLP) Bills }**

Intermediaries use the following guidelines for review of SLP services. They base the review of SLP on effective focused review criteria. They implement the HCFA edits only if data supports their effectiveness in focusing review. These criteria do not apply to SLP services provided under a home health plan of care. The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits.

**Intermediaries do not deny a bill solely on the basis that it exceeds the criteria in the edits.**

The edits are **only** for selecting bills to review or for paying bills without MR if they meet Level I criteria. Intermediaries must not provide automatic coverage up to these criteria. They neither guarantee minimum nor set maximum coverage limits.

**6.1 - Level I Review{tc \12 "6.1 -- Level I Review}**

SLP edits have been developed for a number of diagnoses which were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with these diagnoses will require skilled SLP. The edits do not specify every diagnosis which may require SLP, and therefore, the fact that a given diagnosis does not appear in the edits does not create a presumption that SLP services are not necessary, or are inappropriate. Intermediaries do not approve or deny claims at Level I for medical necessity. They pay claims that pass the edits in Exhibit I and any additional edits approved by the RO without being subjected to Level II MR.

For patients receiving SLP services only (V57.3, Speech therapy) during an encounter/visit, the appropriate V code for the service is sequenced first, and, if documented, the diagnosis or problem for which the services are performed is sequenced second. The intermediary standard

system must program the system to read the diagnosis or problem sequenced second to determine if it meets the Level I SLP edits.

**EXAMPLE:** SLP services V57.3, for a patient with aphasia 784.3. The V code will be sequenced first, followed by the code for aphasia (V57.3, 784.3). Intermediaries edit for aphasia not the V code. They use this same procedure for V57.89, other specified rehabilitation procedure, and V57.9, unspecified rehabilitation procedure.

Providers submit the following documentation, and intermediaries evaluate bills at Level I based upon each of the following:

Facility and Patient Identification	Facility name, patient name, provider number, HICN, age
Diagnosis	The primary diagnosis for which SLP services were rendered must be listed by ICD-9-CM code first; other Dx(s) applicable to the patient or that influence care must follow.
Duration	The total elapsed time in days that SLP services have been rendered beginning with the date treatment was initiated by the billing provider for the diagnosis being treated (includes the last day in the current billing period).
Number of Visits	The total number of visits completed since SLP services were initiated by the billing provider for the diagnosis being treated. Include the last visit in the billing period in the total visits to date. <b>Do not obtain only the visits for this month's billing period.</b> (Value code 52).
Date Treatment Started (Occurrence Code 45)	The date SLP services were initiated by the billing provider for the speech, language and related disorder.
Billing Period.	When SLP services began and ended in the billing period (from/through dates).

## 6.2 – Level II Review

If a bill meets the intermediary's focused MR criteria, they refer it to the Level II MR health professional staff. If possible, they have a speech-language pathologists review SLP bills. Once the bill is selected for focused MR, they review the data in conjunction with medical information submitted by the provider.

### A - Payable SLP Services

Intermediaries pay SLP services only if they meet applicable Medicare coverage requirements. Each bill for SLP services that is subjected to Level II MR must be supported with adequate medical documentation to make a determination. (See MIM §§3101 and 3148.)

### **6.3 - MR Documentation**

When a claim is referred to Level II MR, intermediaries use the following pertinent data elements in addition to those used for Level I review:

Medical History	Intermediaries obtain only the medical history which is pertinent to, or influences the SLP treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring SLP, and any pertinent prior SLP treatment.
Speech, Language, and Related Disorder	The diagnosis or diagnoses established by the speech-language pathologist. Examples are spoken language production disorder (expressive aphasia), dysarthria, and dysphagia.
Date of Onset (Occurrence Code 11)	The date of onset or exacerbation of the speech, language and related disorder diagnosis for which services were rendered by the billing provider.
Physician Referral and Date Received by the Billing Provider	Self-explanatory
Initial Assessment and Date	The procedure used by the speech-language pathologist to diagnose speech, language, and related disorders, and the date the initial assessment is completed by the billing provider.
Plan of Treatment and Date Established	Self-explanatory
Date of Last Certification	Intermediaries obtain the date on that the plan of treatment was last certified by the physician.
Progress Notes	Intermediaries obtain updated patient status reports concerning the patient's current functional communication abilities/limitation.

#### **6.3.1 - Medical History**

If a history of previous SLP treatment is not available, the provider may furnish a general summary regarding the patient's past relevant medical history recorded during the initial assessment with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior treatment for the current condition, progress made, and treatment by the referring physician must be provided when available. The level of function prior to the current exacerbation or onset should be described.

The patient's medical history includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is necessary for patients who have transferred to a new provider for additional treatment. For chronic conditions, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled care.

### **6.3.2 - Assessment {tc \l3 "6.3.2 -- Assessment }**

Intermediaries approve the initial assessment when it is reasonable and necessary for the speech-language pathologist to determine if there is an expectation that either restorative services or establishment of a maintenance program will be appropriate for the patient's condition.

Reassessments are covered if the patient exhibits a demonstrable change in motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated SLP services. Periodic routine reevaluations (e.g., monthly, bimonthly) for a patient undergoing a SLP program are part of the treatment session and are not covered as separate evaluations. An initial assessment or reassessment that is determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the assessment determines that skilled services are not needed.

The assessment establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals. The initial assessment must include objective baseline diagnostic testing (standardized or non-standardized), interpretation of test results, and clinical findings. If baseline testing cannot be accomplished for any reason, note this in the initial assessment or progress notes, along with the reason(s). Include a statement of the patient's expected rehabilitation potential.

### **6.3.3 - Plan of Treatment**

The plan of treatment must contain the following:

- Type and nature of care to be provided;
- Functional goals and estimated rehabilitation potential;
- Treatment objectives;

- Frequency of visits; and
- Estimated duration of treatment.

## **A -- Functional Goals**

Functional goals must be written by the speech-language pathologist to reflect the level of communicative independence the patient is **expected** to achieve outside of the therapeutic environment. The functional goals reflect the final level the patient is expected to achieve, are realistic, and have a positive effect on the quality of the patient's everyday functions.

Intermediaries assume that certain factors may change or influence the final level of achievement. If this occurs, the speech-language pathologist must document the factors which led to the change of the functional goal. Examples of functional communication goals in achieving optimum communication independence are the ability to:

- Communicate basic physical needs and emotional status;
- Communicate personal self-care needs;
- Engage in social communicative interaction with immediate family or friends; or
- Carry out communicative interactions in the community.

**NOTE:** The term "communication" includes speech, language, as well as voice skills.

A functional goal may reflect a small, but meaningful change that enables the patient to function more independently in a reasonable amount of time. For some patients, it may be the ability to give a consistent "yes" and "no" response; for others, it may be the ability to demonstrate a competency in naming objects using auditory/verbal cues. Others may receptively and expressively use a basic spoken vocabulary and/or short phrases, and still others may regain conversational language skills.

## **B - Treatment Objectives**

Treatment objectives are specific steps designed to reach a functional goal. When the patient achieves these objectives, the functional goal is met.

## **C - Frequency of Visits**

Frequency of visits is an estimate of how often the treatments are to be rendered (e.g., 3x week). Length of visits are typically 30, 45, or 60 minutes. Sometimes patients are seen for shorter periods several times a day (e.g., three 10 minute sessions, or a total of 30 minutes). Rarely, except during an assessment, are sessions longer than 60 minutes. If so, the provider must justify them, by noting, for example, that the patient is exceptionally alert, the number of appropriate activities needing skilled intervention is greater than average, special staff/family training is required. Post-operative intensive treatment is sometimes required (e.g., tracheoesophageal puncture) or post-onset of disorder (due to intensive family involvement).

## D - Estimated Duration of Treatment

Estimated duration of treatment refers to the total estimated time over which the services are to be rendered, and may be expressed in days, weeks, or months.

### 6.3.4 - Progress Reports {tc \13 "6.3.4 -- Progress Reports }

Intermediaries obtain progress reports or treatment summary for the billing period including:

- The initial functional communication level of the patient at this provider setting;
- The present functional level of the patient and progress (or lack of progress) specific for this reporting period;
- The patient's expected rehabilitation potential; and
- Changes in the plan of treatment.

Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, intermediaries approve the services up to the time that no further significant practical improvement can be expected. Progress reports must document a continued expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to their levels when treatment was initiated. Intermediaries must not interpret the term "significant" so stringently that they may deny a claim because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's **overall functional ability** will occur. However, the speech-language pathologist and/or physician should document such lack of progress and explain the need for continued intervention.

Documentation includes a short narrative progress report and objective information in a clear, concise manner. This provides the reviewer with the status on progress in meeting the plan of treatment, along with any changes in the goals or the treatment plan. Medical reviewers request that new plans be forwarded with the original so that they can review the entire plan. However, the reviewer must have access to an overall treatment plan with final goals and enough objective information with each claim to determine progress toward meeting the goals.

Consistent reporting is important. For example, if the provider reports that the patient can produce an "m" 25 percent of the time, then reports 40, 60, 90 percent success, the intermediary may believe that treatment might be ending. However, if they have the final goal and the objectives, they can see the progress toward that goal and the steps needed to reach it. The

speech-language pathologist might state that the final goal is "the ability to converse in a limited environment."

One underlying SLP goal might be to "reduce the apraxia sufficiently so the patient can initiate short intelligible phrases with a minimum of errors." Short-term goals may include the patient's ability to initiate easier phonemes before other, more difficult, phonemes. Therefore, the speech-language pathologist has a linguistically and neurologically sound basis for working on one phoneme production before initiating another.

The speech-language pathologist might work on a group of phonemes having a "feature" in common before working on another group. For example, working on all bilabials (since the patient can easily see the movement), might be desirable prior to sounds that are produced more intraorally.

The speech-language pathologist may choose how to demonstrate progress. However, the method chosen, as well as the measures used, generally remain the same for the duration of treatment. The provider must interpret reports of test scores, or comparable measures and their relationship to functional goals in progress notes or reports. Diagnostic testing should be appropriate to the communication disorder.

While a patient is receiving SLP treatment, the speech-language pathologist reassesses the patient's condition and adjusts the treatment. However, if the method used to document progress is changed, the reasons must be documented, including how the new method relates to the previous method. If the speech-language pathologist reports a sub-test score for one month, then a score of a different sub-test the next month without demonstrating the sub-test's interrelationship, you are not able to judge the progress. The intermediary should return these claims for an explanation/interpretation. They may refer the claims to Level III MR if needed.

### **6.3.5 - Level of Complexity of Treatment {tc \13 "6.3.5 -- Level of Complexity of Treatment }**

Intermediaries must base decisions on the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as a reinforcement. It is the speech-language pathologist's analysis that makes the activity skilled.

### **6.3.6 - Reporting on New Episode or Condition {tc \13 "6.3.6 -- Reporting on New Episode or Condition }**

Occasionally, a patient who is receiving, or has previously received SLP services, experiences a secondary or complicating new illness. The provider documents the significance of any change to the communication capabilities. This may be by pre-and post-episodic objective documentation, through nursing notes or by physician reports. If the patient is receiving treatment, it might have to be lengthened because of his change in condition. If the patient has completed treatment, a significant change in the communication status must be documented to warrant a new treatment plan.

### **6.3.7 - Certification and Re-certification**

SLP services must be certified and re-certified by a physician and furnished while under the care of a physician. They must be furnished under a written plan of treatment established by the physician or a qualified speech-language pathologist providing such services. If the plan is established by a speech-language pathologist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When outpatient SLP services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days is required for the review of the plans. Re-certification must be signed by the physician who reviewed the plan of treatment. Any changes established by the speech-language pathologist must be in writing and signed by the speech-language pathologist or by the attending physician. The physician may change a plan of treatment established by the speech-language pathologist. The speech-language pathologist may not alter a plan of treatment established by a physician.

### **6.4 - Qualified Speech-Language Pathologist**

The following information is provided to familiarize the intermediary staff with Medicare requirements for qualifications of speech-language pathologists and specific acronyms commonly used. A qualified speech-language pathologist meets the following criteria:

- A person who is licensed, if applicable, by the State in which he/she is practicing; and
- Is eligible for a certificate of clinical competence in SLP granted by the American Speech Language Hearing Association; or
- Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

A qualified speech-language pathologist normally indicates certification status by utilizing CCC-SLP or CFY-SLP. A CCC-SLP is a Certificate of Clinical Competence in SLP and a CFY-SLP is a Clinical Fellowship Year in Speech-Language Pathology.

### **6.5 - Skilled and Unskilled Procedures**

Certain services are skilled or non-skilled by definition. However, for coverage, the services must be reasonable and necessary based on the MR of the documentation submitted. The following are **examples** of specific types of skilled and non-skilled SLP procedures.

#### **A - Skilled Procedures**

Skilled procedures include:

- Diagnostic and assessment services to ascertain the type, causal factor(s) and severity of speech and language disorders. Reassessment is needed if the patient exhibits a change in functional speech or motivation, clearing of confusion, or remission of some other medical condition which previously contraindicated SLP or audiology services.
- Design of a treatment program relevant to the patient's disorder(s). Continued assessment of progress during the implementation of the treatment program, including documentation and professional analysis of the patient's status at regular intervals.
- Establishment of compensatory skills (e.g., air-injection techniques, word finding strategies).
- Establishment of a hierarchy of speech-language tasks and cueing that directs a patient toward communication goals.
- Analysis related to actual progress toward goals.
- Patient and family training to augment restorative treatment or to establish a maintenance program.

## **B - Unskilled Procedures**

The following are considered unskilled procedures:

- Non-diagnostic/non-therapeutic routine, repetitive and reinforced procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce **previously** learned material which the patient or family is instructed to repeat.
- Procedures which may be effectively carried out with the patient by any nonprofessional (e.g., family member, restorative nursing aide) after instruction and training is completed.
- Provision of practice for use of augmentative or alternative assessment communication systems.

**NOTE:** It is only after the patient has established a high level of consistency of performance in a task with the speech-language pathologist that unskilled techniques can be implemented.

### **6.5.1 - Statements Supporting and Not Supporting Coverage**

This is documentation which is objective or subjective and demonstrates whether there is progress toward a stated functional goal.

## A - Statements Supporting Coverage

Typically, these statements have an objective component which is **compared to previous reports**, and which demonstrate **progress toward a stated functional goal**.

**EXAMPLES:** "Mr. Smith achieved 75 on the Word Subtest on the Johnson Test of Aphasia compared with last month's score of 50 on the same Subtest."

"Mr. Jones achieved a combined score of 352 on the A, B, C, D, and E subtests this month compared with an overall score of 250 for these same subtests last month."

"Mrs. Jones achieved the next steps in the treatment plan outlined last month (see attached sheet). If she continues at this rate, she should complete treatment within the next 2 months."

"Mrs. Jones achieved 75% (7.5 out of 10 or 75 out of 100) on word naming which compares to last month's score of 50% (5.0 out of 10 or 50 out of 100)."

**NOTE:** Percentages should be based on real number count. **Interpretation of scores must be presented in progress notes or summary information.** The narrative should also contain reference to objective scoring, comparison of previous scores, or treatment plan with present status compared to previous status. This information may be embedded in narrative or attached, however, the reviewer should have access to this information and **stated functional goals**.

## B - Statements That Do Not Support Coverage

Typically, statements that do not support coverage are subjective, and do not demonstrate progress toward a stated functional goal, or a comparison to previous test scores.

**EXAMPLES:** "Ms. Jones is very concerned about going home. She has begun smoking again which is causing family as well as physical problems."

"Speech somewhat slurred today."

"Mr. Smith more consistent in responses."

"Mr. Jones has shown significant improvement in his ability to make himself understood."

"Patient is now able to inject air 80% of the time." (No comparison to previous report.)

"Mrs. Smith achieved 75% accuracy on word naming task. (No comparison to previous report)."

"Auditory comprehension improved from moderately impaired to mildly impaired." (By itself, the statement does not offer sufficient objective information.)

### **C - Resumption of Treatment**

There are conditions and circumstances that justify resuming treatment after it has been delayed. Intermediaries obtain verification (when needed for coverage decisions). Examples include:

- Patient becomes more alert, attentive, cooperative;
- Patient shows rehabilitation potential;
- Medical complications cleared;
- Environmental change improves motivation or communicative capabilities;
- Progressive nature of disorder warrants further treatment; and
- Drug or other medical treatment is reduced or ended.

### **6.5.2 - MR Considerations {tc \13 "6.5.2 -- MR Considerations }**

#### **A -- Disorders Typically Not Covered for the Geriatric Patient**

- Stuttering (except neurogenic stuttering caused by brain damage);
- Fluency Disorder;
- Cluttering;
- Disprosody;
- Disfluency;
- Myofunctional Disorders;
- Tongue Thrust; and
- Behavioral/Psychological Speech Delay.

#### **B - Maintenance Program**

Intermediaries approve claims only when the specialized knowledge and judgment of a qualified speech-language pathologist is required to design and establish a maintenance program. By the

time the patient's restorative program has been completed, the maintenance program has already been designed, with instructions to the patient, supportive personnel, or family. They do not approve a separate charge for establishing the maintenance program immediately after the restorative program has been completed.

Intermediaries obtain documentation that justifies a provider reestablishing a maintenance program, e.g., loss in previous functional abilities occurs, intervening medical conditions develop, difficulty in communicating with care-givers arises.

The initial assessment should be documented with standardized testing (if possible) to establish base-line data. This is critical if a claim is submitted for care at a future date. Documentation should show that the maintenance program is designed by the speech-language pathologist appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician.

The maintenance program is established when documentation indicates it has been designed for the patient's level of function and instructions to the patient and supportive personnel have been completed for them to safely and effectively carry them out. The documentation must give reasonable assurances that this has occurred. After that point, the services are not reasonable and necessary.

### **C - Group Treatment**

Generally, group therapy treatment and attendance at social or support groups, such as stroke clubs or lost cord clubs, are not payable. Intermediaries ensure that the "reasonable and necessary" requirements are met.

### **D - Total Laryngectomy**

Total laryngectomy is surgical removal of the larynx. Documentation may involve pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about alternative communication methods, and to provide an immediate means of communication.

Documentation includes assessment and any treatment necessary to establish a means of communication using esophageal speech, an artificial larynx (electronic or pneumatic device), a tracheoesophageal puncture prosthesis, and/or other alternate communication methods.

### **E - Partial Laryngectomy**

A partial laryngectomy is the surgical removal of part of the larynx. Documentation includes the voice problems that require assessment and treatment. Documentation may involve pre-op/post-op sessions as part of the assessment, and to inform the patient, the family, and staff about voice problems. Documentation for rehabilitation includes the assessment and type of treatment required for the voice disorders, as well as base-line objective data and progress notes.

### **F - Total Glossectomy**

A total glossectomy is the surgical removal of the tongue. Total glossectomy results in articulation problems that require assessment and may require treatment. Documentation may include pre-op/post-op sessions as part of the assessment to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication and/or to establish an effective maintenance program. Documentation includes assessment and type of treatment for the articulation disorders. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

### **G - Partial Glossectomy**

A partial glossectomy is the surgical removal of part of the tongue. Documentation should indicate the articulation problems that require assessment and treatment. Documentation may include pre-op/post-op sessions as part of the assessment to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication following surgery. Documentation includes the assessment and type of treatment for the articulation disorders including base-line objective data and progress notes. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

### **H - Congenital Disorders**

Documentation for congenital disorders must always substantiate need, e.g., no previous treatment; the patient's communicative capabilities have recently deteriorated; new, special techniques or instruments have become available; or intervening medical complications have affected SLP communication. Intermediaries approve claims for maintenance or short-term treatment only if objective documentation supports that need.

### **I - Alzheimer's Disease (chronic brain syndrome, organic brain syndrome)**

Objective documentation must indicate the patient's condition, alertness and mental awareness. Documentation must justify that services are needed to establish a reasonable and necessary maintenance program. Review these claims carefully for medical necessity.

### **J - Chronic Conditions**

Intermediaries approve claims for patients with chronic conditions such as MS, ALS, Parkinson's Disease or Myasthenia Gravis if they document a need for reasonable and necessary short-term care or a need to establish a maintenance program. However, clear documentation must be present concerning any prior care or maintenance program designed for the same condition. They approve claims for reasonable and necessary short-term intervention to improve oral and laryngeal strength, speech intelligibility, or vocal intensity, but only when the documentation supports the need to increase function, or to establish a maintenance program.

### **6.5.3 - FMR Evaluation{tc \13 "6.5.3 -- Focused MR Evaluation}**

The HCFA edits will aid in identifying SLP claims for FMR. Intermediaries perform regular evaluations of provider claims which pass or fail the edits. Intermediaries must change the

focused review selection based on the results of the evaluation. For example, a provider billing at an aberrant rate consistently, just below the parameters is to be subjected to focused review.

Intermediaries must be on the alert for any of the following trends or characteristics in developing focused MR:

- Edits with high charges per aggregate bill charges;
- Providers billing a higher than average utilization of specific diagnostic codes that fall just below the edit parameters; or
- Specific principal DX codes, such as those with longer visits and duration, those representing the most frequent denials in pre-pay MR, special codes, and/or certain edit groups such as 1, 3, 5 and 8 in one quarter, and others in the next quarter.

#### **6.5.4 - SLP Terms {tc \13 "6.5.4 -- Speech-Language Pathology Terms }**

##### **A - Agnosia**

Agnosia is the inability to attach meaning to sensory information although the physiologic receptor mechanism is intact.

##### **B - Agrammatism**

Agrammatism is the impairment of the ability to produce words in their correct sequence; difficulty with grammar and syntax.

##### **C - Agraphia**

Agraphia is a disorder of writing. It may result from a central nervous system lesion or from lack of muscular coordination.

##### **D - Anomia**

Anomia is loss of the ability to identify or to recall and recognize names of persons, places or things.

##### **E - Aphasia**

Aphasia is a communication disorder caused by brain damage and characterized by complete or partial impairment of language comprehension, formulation, and use. It excludes disorders associated with primary sensory deficits, general mental deterioration, or psychiatric disorders. Partial impairment is often referred to as dysphasia.

##### **F - Aponia**

Aponia is loss of voice.

## **G - Apraxia**

Apraxia is:

- Disruption in the ability to transmit a motor response along a specific modality; involves disruption of voluntary or purposeful programming of muscular movements while involuntary movements remain intact; characterized by difficulty in articulation of speech, formulation of letters in writing, or in movements of gesture and pantomime.
- In speech, a nonlinguistic sensorimotor disorder of articulation characterized by impaired capacity to program the position of speech musculature and the sequencing of muscle movements (respiratory, laryngeal, and oral) for the volitional production of phonemes.

## **H - Dysarthria**

Dysarthria is the term for a collection of motor speech disorders due to impairment originating in the central or peripheral nervous system. Respiration, articulation, phonation, resonance, and/or prosody may be affected; volitional and automatic actions, such as chewing and swallowing, and movements of the jaw and tongue may also be deviant. It excludes apraxia and functional or central language disorders.

## **I - Dysphagia**

Dysphagia is difficulty in swallowing. It may include inflammation, compression, paralysis, weakness, or hypertonicity of the esophagus.

## **J - Generalization**

Generalization is:

- In conditioning, the eliciting of a conditioned response by stimuli similar to a particular conditioned stimulus.
- Transfer of learning from one environment to a similar environment; the more similar the environments or situations, the greater transfer takes place.

## **K - Hard Glottal Attack**

A hard glottal attack is forceful approximation of the vocal folds during the initiation of phonation.

## **L - Intonation**

Intonation is the linguistic system within a language which is concerned with pitch, stress, and juncture of the spoken language; a unit with specific communicative import, such as interrogation, exclamation, and assertion.

### **M - Lexicon**

Lexicon is total accumulation of linguistic signs, words or morphemes, or both, in a given language; the list of all the words in a language.

### **N - Morphology**

Morphology is a component of grammar concerned with the formation of words, the smallest meaningful unit in a language, as a bridge between phonology and syntax.

### **O - Obturator**

Obturator is (1) Any structure which occludes an opening. (2) Prosthetic appliance, similar to a dental plate, that forms an artificial palate to cover a cleft palate, designed so that the musculature of the palate and pharynx are able to contract around it.

### **P - Paraphasia**

Paraphasia is any error of commission modifying a specific word (sound and morpheme substitution) or of word substitution in the spoken or written production of a speaker or writer.

### **Q - Perseveration**

Perserveration is the tendency to continue an activity, motor or mental, once started, and to be unable to modify or stop even though it is acknowledged to have become inappropriate.

### **R - Phoneme**

Phoneme is the shortest arbitrary unit of sound in a given language that can be recognized as being distinct from other sounds in the language.

### **S - Phonological**

Phonological is a component of grammar determining the meaningful combination of sounds.

### **T - Pitch**

Pitch is acuteness or gravity of a tone, dependent upon the frequency of the vibrations producing it and their intensity and overtone structure. The greater the number of vibrations per unit of time, the higher the pitch and the more acute the tone.

### **U - Pragmatics**

Pragmatics is the functional use of language in context. It includes such factors as intention in communication; sensorimotor actions preceding, accompanying, and following the utterance; knowledge shared in the communicative dyad; and the elements in the environment surrounding the message.

## **V - Prosody**

Prosody is:

- Physical attributes of speech that signal linguistic qualities such as stress and intonation. It includes the fundamental frequency intensity of the voice, and the duration of the individual speech sounds.
- A melody of speech determined primarily by modifications of pitch, quality, strength, and duration; perceived primarily as stress and intonational patterns.

## **W - Psychoacoustics**

Psychoacoustics is the combined disciplines of psychology and acoustics concerned with the study of man's response to sound.

## **X - Semantic**

Semantic is a component of grammar concerned with word meanings and meaningful sentences.

## **Y - Syntactic**

Syntactic is a component of grammar concerned with grammatically well formed structures.

## **6.5.5 - Acronyms and Abbreviations {tc \l3 "6.5.5 -- Acronyms and Abbreviations }**

ADL - Activities of Daily Living.

ALPS - Aphasia Language Performance Scales.

ASHA - American-Speech-Language-Hearing Association.

ASL - American Sign Language.

CVC - Consonant-vowel-consonant.

CPS - Cycles per second. Former unit of measurement for the number of successive compressions and rarefactions of a sound wave within one second of time, now replaced with Hertz (Hz).

Dx - Diagnostic therapy.

MLU - Mean Length of Utterance - Average length of oral expressions as measured by a representative sampling of oral language. It is usually obtained by counting the number of morphemes per utterance and dividing by the number of utterances.

VOT - Voice Onset Time - (1) Time between the release of the stop consonant and the beginning of voicing in the vowel. (2) Time required to initiate sound at the vocal folds.

### **6.5.6 - SLP Tests**

These tests include but are not limited to:

#### **A - Widely Used Adult Language Tests.**

- Ammons Full Range Picture Vocabulary Test;
- Aphasia Clinical Battery I;
- Aphasia Language Performance Scales (ALPS);
- Appraisal of Language Disturbances (ALD);
- Boston Diagnostic Aphasia Examination (BDAE);
- Communicative Abilities in Daily Living (CADL);
- Examining for Aphasia;
- Functional Communication Profile;
- International Test for Aphasia;
- Language Modalities Test for Aphasia;
- Language Proficiency Test (LPT);
- Minnesota Test for Differential Diagnosis of Aphasia;
- Porch Index of Communicative Abilities (PICA);
- Revised Token Test;
- Sklar Aphasia Scale;
- Token Test for Receptive Disturbances in Aphasia;

- Hodson Phonological Process Analysis;
- Clinical Evaluation of Language Functions (CELF);
- Western Aphasia Battery.

### **B - Widely Used Adult Articulation Tests**

- Apraxia Battery for Adults (ABA);
- Assessment of Intelligibility of Dysarthric Speech;
- Compton-Hutton Phonological Assessment;
- Frenchay Dysarthria Test;
- The Fisher-Logemann Test of Articulation Competence;
- Iowa Pressure Articulation Test;
- Templin Darley Test of Articulation.

### **C - Speech and Language Diagnostic Tests**

Speech and language diagnostic tests are an initial assessment (including diagnostic testing, if clinically possible) must be performed **prior** to the commencement of treatment. If the reviewer needs assistance in understanding tests used, consult the speech language pathologist consultant or the American Speech, Language, Hearing Association.

### **6.6 - Outpatient SLP Edits{tc \l2 "6.6 -- Outpatient Speech-Language Pathology Edits }**

Outpatient SLP edits do **not** represent normative (or average) treatment. Intermediaries do not deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

<u>Edit Identification Number</u>	<u>Diagnosis</u>	<u>ICD-9-CM</u>	<u>Number Of Visits</u>	<u>Duration (Days)</u>
1	<b>Malignant Neoplasms</b>			
	Lip	140.0-140.9	28	93
	Tongue	141.0-141.9		
	Salivary glands	142.0-142.9		
	Gum	143.0-143.9		
	Mouth, floor, and other unspecified parts	144.0-145.9		
	Oropharynx	146.0-146.9		

	Nasopharynx and hypopharynx and other ill defined sites.	147.0-149.9		
	Esophagus cervical	150.0		
	upper third	150.3		
	Larynx	161.0-161.9		
	Brain	191.0-191.9		
	Other and unspecified parts of nervous system	192.0-192.1 192.8-192.9		
	Head, face, neck	195.0		
	Brain & spinal cord meninges	198.3 198.4		
2	<b>Benign Neoplasms :</b>			
	Lip, oral cavity and pharynx	210.0-210.9	28	93
	Head, face, neck	215.0		
	Brain and other part nervous system	225.0-225.2 225.8-225.9		
	Carcinoma in situ of lip, oral cavity pharynx	230.0		
	Larynx	231.0		
	Uncertain behavior: salivary glands	235.0		
	Lip oral cavity/pharynx	235.1		
	Larynx	235.6		
	Brain and spinal cord	237.5		
	Meninges	237.6		
	Other and unspecified parts of nervous system	237.9		
	Unspecified nature, brain	239.6		
	Unspecified nature, site unspecified	239.9		
3	<b>Nutrition/Dysphagia:</b>			
	Dysphagia	787.2	13	38
	Feeding difficulties	783.3		
	Problems with swallowing and mastication	V41.6		
4	<b>Developmental/Other Anomalies:</b>			
	Developmental speech or language disorder	315.31-315.9	0	0
	Mental retardation	317-319		
	Cleft palate	749.00-749.04		
	Cleft palate with cleft lip	749.20-749.25		
	Cerebral palsy	343.0-343.9		
5	<b>Central Nervous Systems:</b>			
	Meningitis/Encephalitis	320.0-323.9	28	93
	Intracranial abscess or unspecified site	324.0, 324.9		

	Late effects intracranial abscess or pyogenic infection	326		
	Cerebral degeneration, Alzheimer's Disease (excludes senility)	331.0 331.2	0	0
	hydrocephalus & other	331.3-331.9		
	Parkinson's disease	332.0-332.1	12	62
	Other degenerative disease of basal ganglia	333.0-333.2		
	Huntington's chorea/other	333.4-333.5		
	Dystonias	333.6-33.7		
	Orofacial dyskinesia	333.82		
	Spinocerebellar disease	334.0-334.9		
	Motor neuron disease	335.20-335.29		
	Multiple sclerosis	340		
	Other demyelinating diseases of CNS	341.0-341.9		
6	<b>Central Nervous System</b>			
	Specified/unspecified paralysis	334.8-344.9	6	21
	Other conditions of brain and nervous system	348.1-348.9 3491.-349.9		
	Transient cerebral ischemia	435.0-435.9		
	Other and ill defined cerebrovascular disease	437.0-437.9		
	Late effects CVA	438		
7	<b>Cranial/Peripheral Nerves</b>			
	Trigeminal	350.1-350.9	12	62
	Facial	351.0-351.9		
	Glossopharyngeal	352.1-352.2		
	Mononeuritis unspec.	355.9		
	Idiopathic/unspec.	356.8-356.9		
	Myasthenia gravis	358.0		
	Myoneural disorders	385.2-358.9		
	Myotonic/myopathy disorders	359.2-359.4		
8	<b>Cerebrovascular Disease:</b>			
	Hemiplegia	342.0-342.9	29	108
	Cerebral hemorrhage	430-432.9		
	Occlusion/stenosis	433.0-434.9		
	Acute CVA	436		
	Arterial embolism/thrombosis (unspec.)	444.9		
	Injuries to multiple blood vessels of head and neck	900.82		
	Aphasia	784.3		
9	<b>Respiratory Laryngeal System:</b>			
	Chronic Laryngitis and	476.0-4761	12	62

	laryngotracheitis			
	Other diseases of pharynx, not elsewhere classified	478.20-478.29		
	Polyp of vocal cord or larynx	478.4		
	Other disease of vocal cords	478.5		
	Edema of larynx	478.6		
	Other diseases of larynx, not elsewhere Classified	478.70-478.79		
	Other symptoms involving respiratory system	786.09		
	Paralysis of vocal cords or larynx	478.31-478.34	12	93
10	<b>Voice/Speech Communication:</b>			
	Voice disturbance	784.40-784.49	12	63
	Other speech disturbance	784.5		
	Other symbolic dysfunction	784.69	28	93
11	<b>Intracranial Injury:</b>			
	Concussion	850.2-850.9	20	93
	Cerebral laceration and contusion	851.00-851.99	29	108
	Cerebral hemorrhage	852.00-853.19		
	Intracranial injury	854.00-854.19		
12	<b>Injury Head Mouth/Neck Complicated:</b>			
	Fracture Larynx/trachea	807.5-807.6	12	70
	Mouth/tongue/palate	873.70-873.72		
		873.74-873.79		
	Larynx	874.10-874.11		
	Pharynx			
	Injury to multiple blood vessels of head and neck	874.5		
		900.82		
13	<b>Late Effects of Injuries/Other:</b>			
	Skull and face	905.0	6	31
	Nervous system	907.0-907.1		
	Blood vessel head, neck	908.3		
	Crushing injury face	925		
	Unspecified injuries, Face/neck	959.0		
	Unspecified site	959.9		
	Complications due to unspecified device implant and graft	996.70		
	CNS complications	997.0		
	Unspecified complications	998.9, 999.9		
14	<b>V Codes:</b>			
	History of malignant neoplasm larynx	V10.21	1	1

brain	V10.85		
Problem with communication (including speech)	V40.1	2	14
Problems with hearing	V41.2		
Problem with voice production	V41.4		
Organ or tissue replaced (Larynx)	V43.8	1	1
*Speech –language pathology	V57.3*		
other	V57.89*		
unspecified	V57.9*		
Other aftercare following surgery	V58.4		
Other specified after-care	V58.8		
Follow-up exam/surgery	V67.0		
Following other treatment (other)	V67.59		
Observation for other specified suspected conditions	V71.8		
Other specified examination	V72.8		

\*These codes should be sequenced 1st. The medical diagnosis for which SLP is rendered is sequenced 2nd. For example, a speech encounter for acute CVA would be coded V57.3, 436. The intermediary standard system must be programmed to read the 2nd listed code (CVA-436).

### **7 - MR of Part B Intermediary Outpatient OT Bills{tc \I1 "7 -- MR of Part B Intermediary Outpatient Occupational Therapy (OT) Bills }**

The following is criteria for MR of OT services. Intermediaries use the OT edits to assist the reviewer in conducting focused MR within the intermediary budgeted levels. They focus their review using other selection criteria which is determined to be effective. If they choose to use any of the diagnostic edits listed, they do not change the visits and/or duration parameters without approval from CO. They must conform to the MR requirements for all outpatient claims from rehabilitation agencies, SNFs, hospitals, and HHAs that provide OT in addition to home health services.

The bill types are:

- Hospital = 12X and 13X;
- SNF = 22X and 23X;
- HHA = 34X,
- Rehabilitation agency, public health agency or clinic = 74X; and
- CORF = 75X.

These criteria do not apply to OT services provided under a home health plan of care. The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits.

**Denial of a bill solely on the basis that it exceeds the criteria in the edits is prohibited.**

The edits are **only** for assisting the intermediary in selecting bills to review or for paying bills if they meet Level I criteria. They do not provide automatic coverage up to these criteria. They neither guarantee minimum nor set maximum coverage limits.

**7.1 - Level I Review**

OT edits have been developed for a number of diagnoses. The diagnoses were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with these diagnoses will require skilled OT. The edits do not specify every diagnosis which may require OT, and the fact that a given diagnosis does not appear in the edits does not create a presumption that OT services are not necessary or are inappropriate. Intermediaries do not approve or deny claims at Level I for medical necessity. They pay claims that suspend or pass the edits in Exhibit 1 without being subjected to Level II MR. However, they refer all claims that meet the focused MR criteria to Level II MR.

For patients receiving OT services only (V57.2) during an encounter/visit, providers list the appropriate V code for the service first, and, if documented, list the diagnosis or problem for which the services are performed second. The intermediary standard system must be programmed to read the diagnosis or problem listed second to determine if it meets the Level I OT edits.

**EXAMPLE:** Outpatient rehabilitation services, V57.2, for a patient with multiple sclerosis, 340. The V code will be listed first, followed by the code for multiple sclerosis (V57.2, 340). Intermediaries must edit for multiple sclerosis not the V code. They use this same procedure for V57.81 (Orthotic training) V57.89 (Other) and V57.9 (Unspecified rehabilitation procedure).

The provider must submit the following information on the claim and the intermediary must evaluate bills at Level I based upon:

Facility and Patient Identification	Facility name, patient name, provider number, HICN, age.
Diagnosis	List the primary diagnosis for which OT services were furnished by ICD-9-CM code first. List other Dx(s) applicable to the patient or that influence care second.
Duration	The total length of time OT services have been furnished (in days) from the date treatment was initiated for the diagnosis being treated at the billing provider (including the last day in the current billing period).

Number of Visits	The total number of patient visits completed since OT services were initiated for the diagnosis being treated by the billing provider. The total visits to date (including the last visit in the billing period) must be given rather than for each separate bill (value code 51).
Date Treatment Started (Occurrence Code 44)	The date OT services were initiated by the billing provider for the primary medical Dx for which OT services are furnished.
Billing Period	When OT services began and ended in the billing period (from/through dates).

## 7.2 - Level II Review Process{tc \12 "7.2 -- Level II Review Process}

If a bill is selected for intensified review, intermediaries refer it to the Level II health professional MR staff. If possible, they have occupational therapists review OT bills.

Once the bill is selected for review, they review it in conjunction with the medical information submitted by the provider.

### A - Payable OT Services

Intermediaries reimburse OT services only if they meet all requirements established by the Medicare guidelines and regulations. Each bill for OT services that is subjected to Level II MR must be supported with adequate medical documentation for the reviewer to make a determination. (For additional requirements see MIM §§3101.9 and 3148.)

## 7.3 - MR Documentation{tc \12 "7.3 -- MR Documentation}

When a claim is referred to Level II review, intermediaries use the following pertinent data elements in addition to those used for Level I review:

Medical History	Obtain only the medical history which is pertinent to, or influences the OT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring OT, and any pertinent prior OT treatment.
Date of Onset (Occurrence Code 11)	The date of onset or exacerbation of the primary medical diagnosis for which OT services are being rendered by the billing provider.
Physician Referral and Date	

OT Initial Evaluation and Date

Plan of Treatment and Date Established

Date of Last Certification      Obtain the date on which the plan of treatment was last certified by the physician.

Progress Notes                      Obtain updated patient status reports concerning the patient's current functional abilities/limitations.

The following explains specific Level II documentation principles:

### **7.3.1 - Medical History {tc \l3 "7.3.1 -- Medical History }**

If a history of previous OT treatment is not available, the provider supplies a general summary regarding the patient's past relevant medical history recorded during the initial evaluation with the patient/family or through contact with the referring physician. Information regarding prior OT treatment for the current condition, progress made, and treatment by the referring physician is provided when available. The level of function prior to the current exacerbation or onset is described.

The patient's medical history as it relates to OT, includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is necessary for patients who have transferred to a new provider. For example, if surgery has been performed, obtain the type and date. The date of onset and type of surgical procedure should be specific for diagnoses such as fractures. For other diagnoses, such as arthritis, the date of onset may be general. Establish it from the date the patient first required medical treatment. For other types of chronic diagnoses, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OT.

### **7.3.2 - Evaluation{tc \l3 "7.3.2 -- Evaluation}**

Intermediaries approve an OT initial evaluation, (excluding routine screening) when it is reasonable and necessary for the therapist to determine if there is an expectation that either restorative or maintenance services are appropriate. They approve reevaluations when the patient exhibits a demonstrable change in physical functional ability, requiring reestablishment of appropriate treatment goals, or when reasonable and necessary, for ongoing assessment of the patient's rehabilitation needs. They approve initial evaluations or reevaluations that are

reasonable and necessary based on the patient's condition, even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The OT evaluation establishes the physical and cognitive baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's functional deficits and level of assistance needed forms the basis for the OT goals. Objective tests and measurements are used (when possible) to establish base-line data. The provider documents the patient's functional loss and the level of assistance requiring skilled OT intervention resulting from conditions such as those listed below.

### **A - ADL Dependence**

The individual is dependent upon skilled intervention for performance of ADL. These include, but are not limited to, significant physical and/or cognitive functional loss, or loss of previous functional gains in the ability to:

- Feed, eat, drink;
- Bathe;
- Dress;
- Perform personal hygiene;
- Groom; or
- Perform toileting.

This could include management and care of orthoses and/or adaptive equipment, or customized therapeutic adaptations.

### **B - Functional Limitation**

The individual is dependent upon skilled OT intervention in functional training, observation, assessment, and environmental adaptation due, but not limited to:

- Lack of awareness of sensory cues, or safety hazards;
- Impaired attention span;
- Impaired strength;
- In-coordination;
- Abnormal muscle tone;

- Range of motion limitations;
- Impaired body scheme;
- Perceptual deficits;
- Impaired balance/head control; and
- Environmental barriers.

### **C - Safety Dependence/Secondary Complications**

A safety problem exists when a patient, without skilled OT intervention, cannot handle him/herself in a manner that is physically and/or cognitively safe. This may extend to daily living or to acquired secondary complications which could potentially intensify medical sequelae such as fracture nonunion, or skin breakdown. Safety dependence may be demonstrated by high probability of falling, lack of environmental safety awareness, swallowing difficulties, abnormal aggressive/destructive behavior, severe pain, loss of skin sensation, progressive joint contracture, and joint protection/preservation requiring skilled OT intervention to protect the patient from further medical complication(s).

If the goal is to increase the patient's functional abilities and decrease the level of assistance needed, the initial evaluation must measure the patient's starting functional abilities and level of assistance required.

### **7.3.3 - Plan of Treatment**

The OT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The provider submits changes in the plan with the progress notes. The plan must include the following information.

Type of OT Procedures	Describes the specific nature of the therapy to be provided.
Frequency of Visits	An estimate of the frequency of treatment to be rendered (e.g., 3x week).The provider's medical documentation should justify the intensity of services rendered. This is crucial when they are given more frequently than 3 times a week.
Estimated Duration	Identifies the length of time over which the services are to be rendered in days, weeks, or months.
Diagnoses	Includes the OT diagnosis if different from the medical diagnosis. The OT diagnosis should be based on objective tests, whenever possible.

Functional OT Goals (short or long-term)	Reflects the occupational therapist's and/or physician's description of what functional physical/cognitive abilities the patient is expected to achieve. Assume that factors may change or influence the level of achievement. If this occurs, the occupational therapist or physician explains the factors which led to the change in functional goal(s).
Rehabilitation Potential	The occupational therapist's and/or physician's expectation concerning the patient's ability to meet the established goals.

### 7.3.4 - Progress Reports {tc \13 "7.3.4 -- Progress Reports }

Progress reports or treatment summary for the billing period is used by the provider to document and report the following information:

- The patient's initial functional status;
- The patient's functional status and progress (or lack thereof) specific for this reporting period; including clinical findings (amount of physical and/or cognitive assistance needed, range of motion, muscle strength, unaffected limb measurements, etc.); and
- The patient's expected rehabilitation potential.

Where a valid expectation of improvement exists, the services are covered even though the expectation may not be realized. However, in such instances, the OT services are covered only to the time that no further significant practical improvement can be expected. Progress reports or status summaries must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of functional independence and competence, compared to that when treatment was initiated. Intermediaries should not interpret the term "significant" so stringently that they deny a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience an intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's **overall safety or functional ability** will occur. However, the provider should document the lack of progress and justify the need for continued skilled OT.

The provider must provide treatment information regarding the status of the patient during the billing period. The provider's progress notes and any needed reevaluation(s) must update the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, it must be documented. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect the comparisons between the patient's current functional status and that during the previous billing and/or initial evaluation.

Intermediaries conduct a MR of claims with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is **not** possible. For example, a terminally ill patient may begin to exhibit ADL, mobility and/or safety dependence requiring OT. The fact that full or partial recovery is not possible or rehabilitation potential is not present, does not affect MR coverage decisions. The deciding factor is whether the services are considered reasonable, effective, treatment for the patient's condition and they require the skills of an occupational therapist, or whether they can be safely and effectively carried out by non-skilled personnel. The reasons for OT must be clear, as well as its goals, prior to a favorable coverage determination. They often require Level III review.

It is essential that the provider documents the updated status in a clear, concise, and objective manner. Objective tests and measurements are stressed when they are practical. The occupational therapist selects the method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used is changed, the reasons for the change should be documented, including how the new method relates to the old. The reviewer must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

**Documentation of the patient's current functional status and level of assistance required compared to previous reporting period(s) is of paramount importance. The deficits in functional ability should be clear.** Occupational therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated in objective, measurable terms. The following illustrate these principles and demonstrate that significant changes may occur in one or more of the assistance levels:

#### **7.3.4.1 - Change in Level of Assistance**

Occupational therapist's document assistance levels by describing the relationship between functional activities and the need for assistance. Within the assistance levels of minimum, moderate, and maximum there are intermediate gradations of improvement based on changes in behavior and response to assistance. **Improvements at each level must be documented** to compare the current cognitive and/or physical level achieved to that previously achieved.

While cognitive assistance often is the more severe and persistent disability, physical assistance often is the major obstacle to successful outcomes and subsequent discharge. Intermediaries should interpret the levels as follows:

#### **A - Total Assistance**

Total assistance is the need for 100 percent assistance by one or more persons to perform all physical activities and/or cognitive assistance to elicit a functional response to an external stimulation. An individual requires total assistance if the documentation indicates the patient is only able to initiate minimal voluntary motor actions and requires the skill of an occupational therapist to develop a therapeutic program or implement a maintenance program to prevent, or minimize, deterioration.

A cognitively impaired patient requires total assistance when documentation shows external stimuli are required to elicit automatic actions such as swallowing or responding to auditory stimuli. Skills of an occupational therapist are needed to identify and apply strategies for eliciting appropriate, consistent automatic responses to external stimuli.

### **B - Maximum Assistance**

Maximum assistance is the need for 75 percent assistance by one person to physically perform any part of a functional activity and/or cognitive assistance to perform gross motor actions in response to direction. Patients require such assistance if maximum OT physical support and proprioceptive stimulation is needed for performance of each step of a functional activity, every time it is performed. A cognitively impaired patient, at this level, may need proprioceptive stimulation and/or one-to-one demonstration by the occupational therapist due to the patient's lack of cognitive awareness of other people or objects.

### **C - Moderate Assistance**

Moderate assistance is the need for 50 percent assistance by one person to perform physical activities or constant cognitive assistance to sustain/complete simple, repetitive activities safely. A physically impaired patient requires moderate assistance if documentation indicates that moderate OT physical support and proprioceptive stimulation is needed each time to perform a functional activity.

The records submitted should state how a cognitively impaired patient requires intermittent one-to-one demonstration or intermittent cueing (physical or verbal) throughout the activity. Moderate assistance is needed when the occupational therapist/care-giver needs to be in the immediate environment to progress the patient through a sequence to complete an activity. This level of assistance is required to halt continued repetition of a task and to prevent unsafe, erratic or unpredictable actions that interfere with appropriate sequencing.

### **D - Minimum Assistance**

Minimum assistance is the need for 25 percent assistance by one person for physical activities and/or periodic, cognitive assistance to perform functional activities safely. A physically impaired patient requires minimum assistance if documentation indicates that activities can only be performed after physical set-up by the occupational therapist or care-giver, and if physical help is needed to initiate, or sustain an activity. A review of alternate procedures, sequences and methods may be required. A cognitively impaired patient requires minimal assistance if documentation indicates help is needed in performing known activities to correct repeated mistakes, to check for compliance with established safety procedures, or to solve problems posed by unexpected hazards.

### **E - Standby Assistance**

Standby assistance is the need for supervision by one person for the patient to perform new procedures adapted by the therapist for safe and effective performance. A patient requires such

assistance when errors are demonstrated or the need for safety precautions are not always anticipated by the patient.

## **F - Independent Status**

Independent status means that no physical or cognitive assistance is required to perform functional activities. Patients at this level are able to implement the selected courses of action, demonstrate lack of errors and anticipate safety hazards in familiar and new situations.

### **7.3.4.2 - Change in Response to Treatment Within Each Level of Assistance{tc \14 "7.3.4.2 -- Change in Response to Treatment Within Each Level of Assistance}**

Significant improvement must be indicated by documenting a change in one or more of the following categories of patient responses:

#### **A - Refusals**

The patient may respond by refusing to attempt an activity because of fear or pain. The documentation should indicate the activity refused, the reasons, and how the OT plan addresses them. These responses are often secondary to a change in medical status or medications. If the refusals continue over several days, the therapy program should be put on "hold" until the patient is willing to attempt functional activities.

For the cognitively impaired patient, refusal to perform an activity can escalate into aggressive, destructive or verbally abusive behavior if the therapist or care-giver presses the patient to perform. In these cases, a reduction in these behaviors is considered significant progress, but must be documented, including the skilled OT provided to reduce the abnormal behavior.

For the psychiatrically impaired patient, refusals to participate in an activity frequently are symptoms of the diagnosis. The patient should not be put on a "hold" status due to refusals. If the documentation indicates that the patient is receiving OT, is contacted regularly, and is actively encouraged to participate, intermediaries medically review the claim to determine if reasonable and necessary skilled care has been rendered.

#### **B - Inconsistency**

The patient may respond by inconsistently performing functional tasks from day-to-day or within a treatment session. Intermediaries approve the claim when the documentation indicates a significant progression in consistency of performance of functional tasks within the same level of assistance.

#### **C - Generalization**

The patient may respond by applying previously learned concepts for performing an activity to another, similar activity. The records submitted should document a significant increase in scope of activities that the patient can perform, their type, and the skilled OT services rendered.

Examples of a new skilled functional activity are:

- Adding teaching of lower body dressing to a current program of upper body dressing;
- Increasing the ability to perform personal hygiene activities for health and social acceptance.

Examples of a new skilled compensatory technique (with or without adapted equipment) are:

- Teaching a patient techniques such as one-handed shoe tying;
- Teaching the use of a button hook for buttoning shirt buttons.

The acceptable length of time in treatment for various disorders is determined by the patient's documented functional abilities and progress.

### **7.3.5 - Level of Complexity of Treatment**

Intermediaries base decisions on the level of complexity of the services rendered by the occupational therapist and not what the patient is asked to do.

#### **A - Skilled OT**

The documentation must indicate that the severity of the physical, emotional, perceptual, or cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities. In addition, intermediaries consider instructions required by the patient and/or the patient's care-givers. Instructions may be required for activities that most healthy people take for granted. The special knowledge of an occupational therapist is required to decrease or eliminate limitations in functional activity performance. Occupational therapists must often address underlying factors which interfere with specific activities. These factors could be cognitive, sensory, or perceptual deficits.

The occupational therapist modifies the specific activity by using adapted equipment, making changes in the environment, altering procedures for accomplishing the task, and providing specialized assistance to meet the patient's current and potential abilities. Skilled services include, but are not limited to reasonable and necessary:

- Patient evaluations;
- Determinations of effective goals and services with the patient and patient's caregivers and other medical professionals;
- Analyzing and modifying functional tasks;
- Determination that the modified task obtains optimum performance through tests and measurements;

- Providing instructions of the task(s) to the patient, family, care-givers; and
- Periodically reevaluating the patient's status with corresponding readjustment of the OT program.

A period of practice may be approved for the patient and/or patient's care-givers to learn the steps of the task, to verify the task's effectiveness in improving function, and to check for safe and consistent performance.

## **B - Non-skilled OT**

When the documentation indicates a patient has attained the therapy goals or has reached the point where no further significant improvement can be expected, the skills of an occupational therapist are not required to maintain function at the level to which it has been restored.

Examples of maintenance procedures:

- Daily feeding programs after the adapted procedures are in place;
- Routine exercise and strengthening programs;
- The practice of coordination and self-care skills on a daily basis; and
- Presenting information on energy conservation or pacing, but not having the patient perform the activity.

The intermediary may approve a claim because the patient requires the judgment and skills of the occupational therapist to design a safe and effective maintenance program and make periodic checks of its effectiveness. The services of an occupational therapist in carrying out the established maintenance program are not reasonable and necessary for the treatment of illness or injury and may not be approved.

### **7.3.6 - Reporting on New Episode or Condition**

Occasionally, a patient who is receiving or who has received OT services experiences a new illness. The provider must document the significance of any change to the patient's functional capabilities. This may be through pre and post episodic nursing notes or physician reports. If the patient is receiving treatment, it might be lengthened. If the patient had completed treatment a significant change in the patient's functional status must be documented to warrant a new treatment plan.

## **7.4 - Other MR Considerations**

### **A - Pain**

Intermediaries consider documentation describing the presence or absence of pain and its effect on the patient's functional abilities in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion materially aids correct decisions. Documentation should describe the limitations placed upon the patient's ADL, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

## **B - Therapeutic Programs**

The objective documentation should support the skilled nature of the program, and/or the need for the design and establishment of a maintenance OT program. The goals should be to increase functional abilities in ADL, mobility or patient safety. Documentation should indicate the goals and type of program provided.

Intermediaries may approve claims when the therapeutic program, because of documented medical complications, the condition of the patient, or complexity of the OT employed, must be rendered by, or under, the supervision of an occupational therapist. For example, while functional ADL may be performed safely and effectively by non-skilled personnel, fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled occupational therapist intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or occupational therapist notes. For correct MR decisions, the patient's losses and/or dependencies in ADL, mobility and safety must be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless documentation supports why skilled OT is needed for the patient's medical condition and/or safety.

Intermediaries approve the establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions to supportive personnel and/or family members need to safely and effectively carry it out. They may approve reevaluation when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be justification for readjusting a maintenance program, e.g., loss of previous functional gains.

## **C - Cardiac Rehabilitation Exercise**

OT is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there is also a diagnosed non-cardiac condition requiring it, e.g., a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires OT. (While the cardiac rehabilitation exercise program may be considered by some a form of OT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.)

## **D - Transfer Training**

The documentation should describe the patient's functional limitations in transfer ability that warrant skilled OT intervention. Documentation includes the special transfer training needed to perform functional daily living skills and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Intermediaries approve transfer training when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the activities of daily living or mobility.

Documentation that supports only repetitious carrying out of the transfer method once established, and monitored for safety and completion does not show covered care.

### **E - Fabrication of and Training in Use of Orthoses, Prostheses and Adaptive Equipment**

Intermediaries approve reasonable and necessary fabrication of orthoses, prostheses, adaptive equipment, and reasonable and necessary skilled training needed in their safe and effective use, if documentation indicates the need for the device and training in its use.

### **F - OT Forms**

Documentation may be submitted on a specific form the intermediary requires or may be copies of the provider's record. However, the form must capture the needed MR information. If the reviewer chooses to require a particular form, show the OMB clearance number. The information submitted must be complete. If it is not, intermediaries return the bill for the additional information. The information required to review the bill is that which is required by an occupational therapist to properly treat a patient.

### **G - Certification and Re-certification**

OT services must be certified and re-certified by a physician and must be furnished while the patient is under the care of a physician. OT services must be furnished under a written plan of treatment established by the physician or a qualified occupational therapist. If the plan is established by an occupational therapist, it must be reviewed periodically by the physician. The plan of treatment must be established (reduced to writing by either professional or the provider when it makes a written record of oral orders) before treatment is begun. When outpatient OT services are continued under the same plan of treatment for a period of time, the physician must certify at least at 30-day intervals that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days is required for review of the plans. A re-certification must be signed by the physician, who reviewed the plan of treatment. Any changes to the treatment plan established by the occupational therapist must be in writing and signed by the therapist or by the attending physician. The physician may change a plan of treatment established by the occupational therapist. However, the occupational therapist may not alter a plan of treatment established by a physician.

#### **7.4.1 - OT Availability**

{tc \13 "7.4.1 -- Occupational Therapy Availability }

Two or more disciplines may provide therapy services to the same patient. There may also be occasions where these services are duplicated. In many instances, the description of the services appears duplicated, but the documentation proves that they are not. Some examples where there is **not** a duplication include:

#### **A - Transfers**

PT instructs the patient in transfers to achieve the level of safety with the techniques. OT utilizes transfers as they relate to the performance of daily living skills (e.g., transfer from wheelchair to bathtub).

#### **B - Pulmonary**

PT instructs the patient in an adapted breathing technique. OT carries the breathing retraining into activities of daily living.

#### **C - Hip Fractures/Arthroplasties**

PT instructs the patient in hip precautions and gait training. OT reinforces the training with precautions for activities of daily living, e.g., lower extremity dressing, toileting, and bathing.

#### **D - CVA**

PT utilizes upper extremity neurodevelopmental (NDT) techniques to assist the patient in positioning the upper extremities on a walker and in gait training. PT utilizes NDT techniques to increase the functional use of the upper extremity for dressing, bathing, grooming, etc.

### **7.5 - FMR Analysis{tc \12 "7.5 -- Focused MR Analysis}**

The HCFA edits may assist the intermediary in identifying OT claims for FMR. Intermediaries perform regular evaluations of provider claims which pass or fail the edits. They must change the focused review claims selection based on the results of the evaluation. For example, a provider with an aberrant billing rate consistently just below the edit parameters is subject to intensified review. They develop procedures for FMR based on each of the following trends or characteristics:

- Edits with high charges per aggregate bill charges;
- Providers billing a higher than average utilization of specific diagnostic codes that fall just below the edit parameters; and
- Specific principal DX codes, such as those with longer visits and duration; those representing the most frequent denials in pre-pay MR; special codes, e.g., 585, Chronic Renal Failure; 733.1, Senile Osteoporosis; and 290.0-290.9, Senile and Presenile Organic Psychotic Conditions; and/or certain edit groups such as 17, 19, and 29 in one quarter and others in the next quarter.

## 7.6 - Outpatient OT Edits{tc \12 "7.6 -- Outpatient Occupational Therapy Edits}

The following edits do **not** represent normative (or average) treatment. It is prohibited to deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

<u>Edit Identification Number</u>	<u>Diagnosis</u>	<u>ICD-9-CM</u>	<u>Number Of Visits</u>	<u>Duration (Days)</u>		
1	<b>Neoplasms:</b>					
	Bone and articular cartilage	170.0-170.3	16	48		
	Connective tissue	171.0-171.2				
	Female breast	174.0-174.9				
		198.81				
	Bone or breast, NOS	239.2-239.3				
	Brain and nervous system	191.0-192.9				
	Hodgkin's Disease	201.0-201.9				
	Multiple myeloma	203.0-203.8				
	Leukemia	204.0-208.9				
	Brain and spinal cord and nervous System	237.5-237.9				
		170.4-170.5			24	62
	Bone and articular cartilage, upper limb	225.0-225.9				
	Brain and nervous system	239.6				
2	Schizophrenic disorder	295.30 thru 295.45 295.80-295.95			13	31
	Affective psychosis	296.00-296.99				
3	Parkinson's Disease	332.0-332.1	13	38		
4	Meningitis/Encephalitis	320.0-323.9	16	62		
	Intracranial and intraspinal abcess	324.0-324.9				
	Other extrapyramidal disease	333.0				
	Hydrocephalus and other cerebral	331.1-331.7				
	Degeneration	331.89				
	Huntington's Chorea and other	333.4-333.9				
	Choreas					
	Spinocerebellar disease	334.0-334.9				
	ALS and other motor neuron diseases	335.20-335.9				
	Other diseases of the spinal cord					
	Unspecified disorder of autonomic N.S.	336.0-336.9				
Multiple Sclerosis	337.9					
Demyelinating Diseases of CNS						

	Hemiplegia (old unspecified)	340		
	Other unspecified disorders of Nervous system	341.8-341.9 342.0-342.9		
	Infantile cerebral palsy			
	Late effects of CVA	349.0-349.9		
	Other conditions of brain	343.0-343.9		
	Other ill defined cerebrovascular Diseases	438 348.0-348.9		
	Intracranial injury	437.0-437.9		
		851.00-854.19		
5	Cerebral hemorrhage, occlusion, Stenosis CVA, acute	430-434.9 436	28	72
	Concussion, Loss of consciousness Without return to previous level	850.4		
	Intracranial injury including those With skull Fx	800.70-800.99 801.70-801.99 803.20-803.49 803.70-803.99 804.70-804.99 800.30-800.49 801.49 804.20-804.49		
6	Other paralytic syndromes, paraplegia Quadriplegia	344.0-344.9	32	93
7	Late effects polio	138	13	40
	Disorders of peripheral nerves	353.0-356.9 357.1-359.9	16	62
	Fx of vertebral column	806.00-806.5	30	93
	With spinal cord injury	806.8-806.9		
	Spinal cord injury without Spinal bone injury	952.00-953.1 953.4 & 953.8	24	62
	Peripheral nerve injury	955.0-955.9 957.0-957.9		
	Acute infective polyneuritis	357.0		
	Disturbance of skin	782.0	12	38
8	Diabetes with peripheral circulatory Disorders	250.00-250.01	16	2
	Diseases of circulatory system	250.60-250.71	12	38
	Postmastectomy lymphedema	402.0-429.9	10	31
	Other lymphedema	457.0-457.1		

9	Chronic ulcer of skin	707.0-707.9	12	31
	Diabetes, ulcer (skin)	250.80-250.81		
	Cellulitis, finger	681.00-681.02		
	Open wounds	880.00-884.2		
	Burns (second degree)	941.20-941.29	18	62
		942.20-942.29		
		943.20-943.29		
		944.20-944.28		
		946.2 & 949.2		
10	Emphysema, asthma	492.0-493.91	8	31
	Chronic airway obstruction	496		
11	Chronic renal failure	585	12	38
	Acute renal failure	584.9		
	Nephritis, nephropathy	583.9		
	Renal failure unspecified	586		
12	Lupus erythematosus	695.4	16	62
	Diffuse disease of connective tissue	710.0-710.9		
	Arthropathy associated with infection	711.00-711.59		
	Rheumatoid arthritis and inflammatory	714.0-714.9		
	Palyarthropathies			
	Gouty arthropathy	274.0		
13	Osteoarthritis and allied disorders	715.00-716.99	13	31
14	Internal derangement of joint, other	718.00-718.99	16	48
	Derangement of joint and other			
	Unspecified disorders of joint			
15	Dorsopathies	720.0-722.0	13	31
		723.0		
		723.3-723.4		
		723.9		
	Osteitis deformans	731.0		
	Aseptic necrosis	733.40-733.41		
	Disorder of bone and cartilage	733.81-733.99		
	Other acquired deformities	738.8-738.9		
		756.9		
	Other and unspecified anomalies of			
	Musculo-skeletal system	730.00-730.29		
	Osteomyelitis	736.00-736.89		
	Acquired deformities	733.1	12	31
	Pathological Fx			



23	Amputation upper lower	885.0-887.7	32	93
		897.0-897.7	12	38
24	Burns (3 <sup>rd</sup> and 4 <sup>th</sup> degree)	941.30-941.59	32	93
		942.30-942.55		
		942.59		
		943.30-943.56		
		943.49		
		944.30-944.58		
		946.3-946.5		
949.3-949.5				
25	Joint replacement	V43.6	18	48
	Problem with limbs	V49.0-49.9	13	31
	Convalescence following Fx	V66.4		
	Follow-up exam FX	V67.4		
	Fitting and adjustment of prosthetic	V52.0		
	Device, Artificial arm Other orthopedic			
	Aftercare involving removal internal			
	Fixation device	V54.0	10	31
	Observation for specified suspected			
	Condition	V71.8		
	Orthopedic aftercare		12	38
	Other aftercare following surgery	V54.8-V54.9		
	Other specified aftercare	V58.4		
	Unspecified aftercare	V58.8		
	Other follow-up exam	V58.9		
	Late effects Fx spine and upper	V67.59, V67.9	13	38
	Extremities	905.1-905.2		
	Late effects tendon injury			
	Late effects traumatic amputation	905.8		
Late effects of injuries	905.9			
Complications of surgical and	906.0-909.9			
Medical care	996.4			
	996.60-997.1			
	997.6-997.9			
	998.3 & 998.5			
	998.8-998.9			
	999.9			
26	Malnutrition (moderate) protein/calorie	263.0	13	38
	Abnormal weight loss	263.8-263.9		
	Feeding difficulties	783.2		
	Dysphagia	783.3		
		787.2		

## **8 - Forms HCFA-700/701, Outpatient Rehabilitation Services Forms {tc \l1 "8 -- Forms HCFA-700/701, Outpatient Rehabilitation Services Forms }**

The outpatient rehabilitation services forms, Forms HCFA-700/701, are combined MR, certification/re-certification, plan of treatment forms for outpatient Part B, PT, OT and SLP. The forms' design promotes national consistency in reporting and reducing unnecessary requests for additional medical records. HCFA will not mandate use of the hard copy Forms HCFA 700/701. However, some providers have made significant investments in the use of these forms. Therefore, intermediaries must accept hard copy versions of the Forms HCFA-700/701 if the provider chooses to use them. Providers complete the Form HCFA-700 only for initial bills. For interim-to-discharge bills, the provider completes the Form HCFA-701.

Intermediaries use the forms as a source of supporting medical information. They request forms HCFA-700/701 when the reviewers need supporting medical information to help determine whether services are reasonable and necessary.

Intermediaries base payment and denial decisions on information contained in these forms. However, they request additional information when additional medical information is needed to support a decision. A denial determination may not be made solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on data related to utilization.

Instead, reviewers must make determinations based upon clear objective clinical evidence concerning the beneficiary's unique medical condition and individual need for care. They do not routinely require providers to submit the Forms HCFA-700/701. They request only the Form HCFA-700 for initial bills and obtain the Form HCFA-701 for subsequent bills. They obtain photocopies of prior months forms HCFA-700/701 only when needed for coverage determinations.

If the intermediary standard system can retrieve previously submitted Forms HCFA-700/701 information/data, intermediaries inform providers not to send copies.

Providers must complete all applicable items on the forms. However, if an item is blank and a coverage determination can be made, intermediaries should process the claim. Providers may complete items with "N/A," not applicable, when the item does not apply (e.g., no hospitalization occurred). If information is needed for a coverage decision in an item marked as "N/A" (or left blank), they request the information from the provider.

Intermediaries obtain completed forms HCFA-700/701 from acute hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, public health agencies, and clinics (bill types 12X, 13X, 22X, 23X, 34X, 74X, and 75X). They obtain a separate form for each therapy discipline (revenue code) billed.

For example, if a patient received treatment for two services (i.e., PT and OT), the provider must submit two forms. These forms may also be used for outpatient hospital cardiac

rehabilitation, respiratory therapy, or psychiatric services. CORFs may also use the forms for SN and MSS.

## **8.1 - Electronic Attachments {tc \12 "8.1 -- Electronic Attachments }**

Providers submitting batch attachments must use the current version of the UB-92 flat file record type 77. This information may be sent with claim data or independent of claim data. See MIM Addenda A, B, and D and PIM Chapter 9§ for further instructions. Intermediaries require the provider to maintain the information to support the electronic format in the beneficiary's medical record, whether hard copy, or electronic. They request additional information to support a decision only as necessary.

### **8.1.1 - Instructions for Completion of Form HCFA-700, Plan of Treatment for Outpatient Rehabilitation {tc \13 "8.1.1 -- Instructions for Completion of Form HCFA-700, Plan of Treatment for Outpatient Rehabilitation }**

The provider submits the following information on the Form HCFA-700:

- |   |                       |  |
|---|-----------------------|--|
| 1 | Patient's Name        | This item indicates the patient's last name, first name, and middle initial as shown on the health insurance card.   |
| 2 | Provider Number       | This item indicates the six digit number issued by Medicare to the provider. The number contains two digits, a hyphen, and four digits (e.g., 00-7000).  |
| 3 | HICN                  | This item indicates the numeric plus alpha indicator(s) as shown on the patient's health insurance card, certification award, utilization notice, temporary eligibility notice, or as reported by the Social Security Office.  |
| 4 | Provider Name         | This item indicates the name of the Medicare billing provider.   |
| 5 | Medical Record Number | This item indicates the patient's medical/clinical record number issued by the billing provider.   |
| 6 | Onset Date            | This item indicates either the onset date of the primary medical diagnosis (if it is a new diagnosis) or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, "01" is used for the day (e.g., 020199). This date must match Occurrence Code 11 on the UB-92. |
| 7 | SOC Date              | This item indicates the six digit month, day, and year on which rehabilitation services began at the billing provider, i.e., MMDDYY (021599). <b>The SOC date is the first Medicare billable visit (normally the date of initial evaluation). This</b>   |

**date remains the same on subsequent claims until the patient is discharged or the claim is denied.** A provider may suspend services and later resume them under the same SOC date in accordance with its internal procedures. The SOC date may also reflect a re-initiation after discharge or denial if for an exacerbation. For PT, the SOC date must correspond to Occurrence Code 35 on the UB-92, for OT code 44, for SLP code 45, and for CR code 46.

- |    |                                       |  |
|----|---------------------------------------|--|
| 8  | Type                                  | The provider checks this item for the type of therapy furnished, i.e., PT, OT, SLP, for outpatient hospital cardiac rehabilitation, respiratory therapy, or psychiatric services. CORFs may also check SN and/or MSS.  |
| 9  | Primary Diagnosis                     | This item indicates the medical DX that has resulted in the therapy disorder and which is most closely related to the current plan of care for therapy. The diagnosis may or may not be related to the patient's most recent hospital stay but must relate to the services furnished by the provider. If more than one diagnosis is treated concurrently, the provider enters the diagnosis that represents the most intensive services (over 50 percent of rehabilitation effort for the revenue code billed). The primary DX may change on subsequent forms if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than established on the initial plan of treatment. In all such instances, the date treatment started at the billing provider remains the same until the patient is discharged. |
| 10 | Treatment Diagnosis                   | This item indicates the DX for which rehabilitative services were furnished (e.g., for SLP the treatment DX is a communication disorder). For example, while cerebrovascular accident (CVA) may be the primary medical DX, aphasia might be the SLP treatment DX. If the treatment DX is the same as the medical DX, the word "same" is used in this item.   |
| 11 | Visits From Start of Care             | This item indicates the cumulative total visits that were completed since the start of services at the billing provider for the treated DX through the last visit on the bill. This total corresponds to the UB-92 Value Code 50 for PT, 51 for OT, 52 for SLP, or 53 for CR.  |
| 12 | Plan of Treatment<br>Functional Goals |  |

A	Functional goals	This item indicates the initial short and long-term goals in measurable, objective, and functional terms. Included are the functional levels (or safety levels) the patient is expected to achieve upon discharge as a result of therapy services. Also, indicated are the levels the patient is to achieve outside of the therapeutic environment. Time-oriented goals are entered when applicable. For example, communicate basic physical needs and emotional status within weeks (as a functional goal for SLP).
B	Plan	This item indicates the initial overall plan of care, type, and specific nature of rehabilitation procedures that are to be furnished (i.e., treatment the therapist is using: procedures or modalities used).
13	Signature	The signature (or name) and professional designation of the professional who established the plan of treatment is entered in this item. A qualified therapist or speech/language pathologist may establish the plan of treatment for PT, OT, or SLP.
14	Frequency Duration	This item indicates the frequency of treatment the provider expects to furnish per day, week, or month. Also, projected is the length of time the provider expects to furnish services. This is to be expressed in days, weeks, or months (e.g., 3/Wk x 4 Wks).
15	Physician's Signature	The physician signs and dates this item if the Form HCFA-700 is to be used as the physician's certification. If you use an alternative signed certification form, the "On File" box should be checked (Item 18). Identify the period of certification in Item 17 on the HFCA-700. When certification is not required, the provider uses "N/A." Rubber signature stamps are not acceptable as the physician signature. The provider must keep the form containing the physician's original signature on file at the provider site.
16	Date	This item indicates the date the physician signed the form in 6 digits (i.e., month, day, and year).
17	Certification	This item indicates the six digit month, day, and year (i.e., MMDDYY 021599-041599) which identifies the period covered by the plan of treatment. The "From" date for the

initial certification must match the SOC date. The "Through" date can be up to, but never exceed, 30 days (60 days for CORFs). The "Through" date is repeated on a subsequent recertification as the next sequential "From" date. Services delivered on the "Through" date are covered in the next recertification period.

- 18      On File                      This box is checked if the provider uses the form for certification. The provider is to enter the name of the physician who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in Item 8, the name of the physician who referred or ordered the service should be entered, but the "On File" box is not to be checked.
- 19      Prior Hospitalization              This item indicates the six digit month, day, and year (inclusive dates) of the most recent hospitalization that is pertinent to the patient's condition or primary DX billed (date from 1st day of admission through discharge day). The provider enters "N/A" if this is not applicable. If the period is not known, they enter "N/A."
- 20      Initial Assessment              This item indicates a brief historical narrative of the injury or illness and the reason(s) for referral as they relate to the primary or treatment DX. The providers use the following guidelines when constructing their narrative:
- Describe pertinent functional deficits and clinical findings and problems found on the initial assessment.
- Use objective, measurable terminology such as tests and measurements;
- Assess the patient's ADL, ROM, strength, functional abilities, psychological status, level of assistance required, and pertinent speech-language functional deficit findings. Include tests administered with scores;
- Relate pertinent safety precautions and medical complications which require skilled intervention that may affect a patient's progress or attainment of goals;
- List the patient's rehabilitation potential, cognitive status that affects functional ability, and psychological, respiratory, cardiac tests and measurements, as appropriate; and

Document audiologic results, vision status, and use or status of amplification for patients receiving speech reading services.

- 21      Functional Level      This item indicates the patient's functional physical, cardiac, respiratory, or psychological status reached **at the end of the claim period**. The provider is to compare results to that shown on the initial assessment (Item 20). Record functional levels and progress in objective terminology. Include test results and measurements as appropriate. Record information about any change in functional level related to the goal(s) of treatment. When only a few visits have been made (e.g., evaluation) and when there is no change in function, the training/treatment furnished and the patient's response to the visit(s) are recorded. The provider checks the box titled "Continue Services" if services were continued. The provider checks the box titled "DC Services" if services were discontinued (e.g., if the patient was discharged).
- 22      Service Dates      This item indicates the "From/Through" dates that represent this billing period. If the provider uses this form for certification (with the exception of CORFs), this billing period should be monthly. The "From/Through" dates in field 22 on the UB-92 must match the dates in this item. Providers may not use "00" in the date, e.g., 042799 for April 27,1999.

### **8.1.2 - Instructions for Completion of Form HCFA-701, Updated Plan Progress for Outpatient Rehabilitation**

Fields 1 through 11 are the same on forms HCFA 700 and HCFA 701. The provider submits the following information for the remaining fields on the Form HCFA-701:

- 12      Current Frequency      This item indicates the frequency of treatment the provider expects to furnish per day, week or month. Also, projected is the length of time the services are expected to be furnished per days, weeks, or months (e.g., 3/Wk x 4 Wks).
- 13      Current Plan Update,      This item indicates the functional treatment goals for the Functional Goals      patient for this billing period. The provider is to state the goals in measurable, objective terms. They are to stress functional short-term goals to reach overall long-term outcomes that the patient is expected to achieve upon discharge (Item 12, HCFA-700). They are to document changes to the initial plan of treatment and effective date(s). Providers must estimate time-frames to reach goals when possible. They are to record procedures or modalities used. If appropriate, they are to

describe justification of intensity or any changes to the initial plan in Item 18.

- 14 Re-certification This code indicates the six digit month, day, and year, i.e., MMDDYY (061598-071598), that identifies the period covered by the plan of treatment. The "From" date for the initial certification must match the SOC date. The "Through" date can be up to, but never exceed 30 days (60 days for CORFs). The provider is to repeat the "Through" date on a subsequent recertification as the next sequential "From" date. Services delivered on the "Through" date are covered in the next recertification period. On interim CORF claims, "N/A" is used.

**EXAMPLE:** Initial certification "From" date 051599. Initial certification "Through" date 061599. Re-certification "From" date 061599. Re-certification "Through" date 071599. Certification/re-certification is **required for outpatient PT, OT, and SLP and CORF plans of care. Certification is required for partial hospitalization PS.** When certification/re-certification is not required, the provider uses "N/A."

There is no requirement that the provider enter the certification on the Forms HCFA-700/701 or handle it in any specific way as long as the reviewer can determine, where necessary, that certification/re-certification requirements are met.

- 15 Physician Signature If the provider uses the Form HCFA-701 as the physician's recertification, the physician must sign and date the statements. If not, when appropriate, the "On File" box in Item 17 must be checked. Identify the period of recertification in Item 14 on the form. For interim CORF claims and when re-certification is not required, the provider must use the "N/A" box. If the physician established the plan of treatment, the physician must sign both Items 15 and 19. If the plan of treatment is established by a physical therapist, occupational therapist, or speech-language pathologist, that therapist or speech-language pathologist must sign the plan (Item 19). A physician who has knowledge of the care signs the certification/re-certification.
- 16 Date This item indicates the date the physician signs the certification/re-certification in six digits (month, date, and year). The date must be shown even if the provider checks the "On File" box in Item 18.
- 17 On File When the "On File" box is checked, request the certification/re-certification in accordance with your internal procedures, that

are approved by your Regional Office (RO).

- |    |  |  |
|----|--|--|
| 18 | Reason(s) for Continuing Treatment This Billing Period | This item indicates the major reason(s) justifying continued therapy and the need for additional rehabilitation. Safety/medical complications are to be stated when further applicable. In the event of discharge, the provider is to provide the reason.  |
| 19 | Signature  | The professional who furnishes care or supervises services must enter his/her signature and professional designation.  |
| 20 | Date   | This item indicates the date of the signature in 6 digits (month, day, and year).  |
| 21 | Continued or Discontinued                              | The provider checks this box to identify whether services are continued, or discontinued (last bill).  |
| 22 | Functional Level (end of claim period)                 | This item indicates the functional level(s) and progress made at the <b>end of the billing period</b> . Obtain objective tests and measurements when practical. The providers are to date specific short-term gains <b>when practical</b> (e.g., when the patient is able to consistently perform them in this billing period). Providers are to document pertinent safety problems and/or precautions needed. They are to update the patient's current functional level(s) and progress (or lack of progress with an explanation) achieved as compared to the previous month and/or initial assessment. They are to document assistive devices used. Providers are to submit concise, quality, objective documentation and restrict subjective quantity. They should avoid such terms as "improved strength" or "improved communication." Providers billing 5 or more visits per week should use this space to update progress at 2 weeks and at the end of the claim period. |

**NOTE:** When relating functional level(s) and progress made, the reviewer considers that a patient might not progress (or progress little) during a part of a claim period and the patient notes will reflect that fact. This should not be interpreted so stringently to result in an impulsive termination of coverage at that point. Medically review the entire period (including the prior month in relation to the full month in question) to determine coverage.

- |    |               |   |
|----|---------------|---|
| 23 | Service Dates | This item indicates the "From and Through" dates which represent the billing period. If the Provider uses the form for certification/re-certification, with the exception of CORFs, the |
|----|---------------|---|

provider bills monthly. The "From and Through" dates in field 23 are to match the dates on UB-92. Providers should not use "00" in the date, e.g., 042799 for April 27, 1999.

## **9 - MR of ESRD Claims {tc \l1 "9 -- MR of ESRD Claims }**

Medicare beneficiaries covered under the ESRD benefit and dialyzing at home may choose between two methods on how they wish to have the Medicare program pay for home dialysis care (exclusive of physician services). Home dialysis treatments billed under Method I are billed and paid under the composite rate payment system.

All items and services covered and included under the composite rate must be furnished by the facility, either directly or under arrangements, to all of its dialysis patients who elect this method. If the facility fails to furnish any part of the items and services covered under the rate, it cannot be paid for the items and services that it does furnish.

Method II allows beneficiaries the right to deal directly with the Medicare program and make arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing with the facility, the various suppliers and the Medicare program to arrange for payment.

All dialysis treatments provided in a facility are billed under Method I. MR assures that payment is made only for covered items and services as described in MIM §3165ff. and that they do not exceed the patient's medical needs.

### **9.1 - Review of ESRD Claims {tc \l2 "9.1 -- Review of ESRD Claims }**

The volume of claims selected for review should be consistent with the intermediary's annual budget guidelines. Intermediaries should not use random sampling but use selection methods which permit the most cost effective review. They focus the review on specific providers or problem areas or any parameters which provide the highest potential for identifying overutilization or inappropriate billing. They review claims for Epoetin (EPO) exceeding the parameters below if the focused review analysis shows this to be a cost effective review. For selected claims, intermediaries should:

- Request appropriate documentation covering the billing period.
- Review the claims to assure that the ancillary services adhere to the medical necessity guidelines in MIM §§3165ff. and billing instructions in MIM §3644.
- If documentation supplied by the facility does not support the need for the services, or the facility fails to submit the requested documentation, intermediaries deny the services. They send a notice to the beneficiary and provider.
- If the documentation shows that the items or services billed separately are included in the composite rate, intermediaries delete the charges and adjust the payment. They send a notice to the provider. See the following for suggested format.

**A -- NOTICE I**

Provider Name: \_\_\_\_\_ Beneficiary Name: \_\_\_\_\_  
Provider Address: \_\_\_\_\_ HICN: \_\_\_\_\_  
\_\_\_\_\_  
From: \_\_\_\_\_ Thru: \_\_\_\_\_  
Provider No. \_\_\_\_\_

In the ongoing review of composite rate dialysis claims, we have determined the following items on the claim should have been included in the rate:

LAB \_\_\_\_\_  
PHARMACY \_\_\_\_\_  
SUPPLIES \_\_\_\_\_  
OTHER \_\_\_\_\_

Claims will continue to be carefully reviewed and improper charges will be deleted. Provider cooperation in making corrections in future billings will be appreciated.

**B -- NOTICE II**

Provider Name: \_\_\_\_\_ Beneficiary Name: \_\_\_\_\_  
Provider Address: \_\_\_\_\_ HICN: \_\_\_\_\_  
\_\_\_\_\_  
From: \_\_\_\_\_ Thru: \_\_\_\_\_  
Provider No. \_\_\_\_\_

Please refer to our previous correspondence regarding the review of your composite rate dialysis claims. The following items are consistently billed in error:

LAB \_\_\_\_\_  
PHARMACY \_\_\_\_\_  
SUPPLIES \_\_\_\_\_  
OTHER \_\_\_\_\_

The intermediary will continue to closely monitor your claims and delete these improper charges. Again, provider cooperation in making corrections in future billings will be appreciated in correcting this problem.

**9.1.1 - Guidelines for Review of Claims for Epoetin (EPO){tc \l3 "9.1.1 -- Guidelines for Review of Claims for EPO.}**

EPO is indicated in the treatment of anemia associated with chronic renal failure, including dialysis patients. It is not intended for patients who require immediate correction of severe anemia. It may obviate the need for maintenance transfusion, but is not a substitute for emergency transfusion. The effectiveness of the drug can be influenced by the presence of one of the following:

- Iron deficiency;

- Infection, inflammation or malignancy;
- Unrecognized blood loss;
- Folic acid or vitamin B12 deficiencies;
- Concomitant hemolysis, bone marrow dysplasia or refractory anemia for a reason other than renal disease; and
- Circumstances in which bone marrow is replaced with other tissue.

The drug is contraindicated in patients with:

- Uncontrolled hypertension;
- Known sensitivity to mammalian cell-derived products; and
- Known sensitivity to Human Albumin.

The usual route of administration is intravenous (IV) or subcutaneous (SC). Dosage is calculated based on the patient's body weight. Starting doses in the range of 50-100 u/kg of body weight 3 times a week were shown to be safe and effective in clinical trials. EPO is generally initiated when the hematocrit is less than 30, or the hemoglobin is less than 10 and the creatinine is 3 or higher. The provider must document the medical necessity for initiation of EPO therapy if the hematocrit is greater than 30, or the hemoglobin is greater than 10 and/or the creatinine is less than 3.

The dosage of EPO must be individualized to maintain the hematocrit within the suggested hematocrit target range of 30-36 percent. The dose of EPO should be reduced as the hematocrit approaches 36 percent or if the hematocrit increases by more than 4 points in any 2-week period. EPO should be temporarily withheld if the reduced dose does not stop the rise in the hematocrit and the hematocrit exceeds 36 percent. However, intermediaries do not automatically deny claims because the hematocrit exceeds 36 percent. There are instances where there is justification for EPO to be continued. This depends upon the clinical conditions and the provider must justify the necessity for continuation of the therapy.

All claims for EPO from dialysis facilities should contain the anemia codes 285.8, Other specified anemias, or 285.9, Anemia unspecified, and one of the following renal disease codes:

403.01 403.11 403.91 404.02 404.03 404.12 404.13 404.92 404.93 585 586

However, the absence of either of the above named anemia codes does not preclude coverage for the administration of the drug. In the latter case, intermediaries extend coverage to additional anemia diagnoses on the advice of the intermediary medical consultant provided the treatment is determined to be reasonable and necessary for the condition.

On initial claims for EPO, the provider must report the most recent hematocrit and creatinine (and the date each was performed) prior to the initiation of EPO therapy. On subsequent claims, the provider must report the **latest** hematocrit or hemoglobin performed in the billing period.

The hemoglobin (value code 48) or hematocrit (value code 49) and the total units of EPO administered during the billing period (value code 68) must be reported in Items 46-49 on the UB-92.

Other documentation which the provider is to maintain in the patient's medical record is:

- The patient's weight in kilograms;
- The EPO units administered per kilogram of body weight; and
- Medical justification for administration of EPO exceeding standards of normal clinical practice.

**A B EPO Exhibit 1**

Provider Name: \_\_\_\_\_ Beneficiary Name:  
\_\_\_\_\_

Provider Address: \_\_\_\_\_ HICN: \_\_\_\_\_

From: \_\_\_\_\_ Thru: \_\_\_\_\_

Provider No. \_\_\_\_\_

In the ongoing review of composite rate dialysis claims, we have determined the following items on the claim should have been included in the rate:

LAB \_\_\_\_\_

PHARMACY \_\_\_\_\_

SUPPLIES \_\_\_\_\_

OTHER \_\_\_\_\_

Claims will continue to be carefully reviewed and improper charges will be deleted. Your cooperation in making corrections in your future billings will be appreciated.

**B B EPO Exhibit 2**

Provider Name: \_\_\_\_\_ Beneficiary Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_ HICN: \_\_\_\_\_

From: \_\_\_\_\_ Thru: \_\_\_\_\_

Provider No. \_\_\_\_\_

Please refer to our previous correspondence regarding the review of your composite rate dialysis claims. The following items are consistently billed in error:

LAB \_\_\_\_\_

PHARMACY \_\_\_\_\_

SUPPLIES \_\_\_\_\_

OTHER \_\_\_\_\_

We will continue to closely monitor your claims and delete these improper charges. Again, we urge your cooperation in correcting this problem.

**10 - Special Instructions for MR of Dysphagia Claims {tc \11 "10 -- Special Instructions for MR of Dysphagia Claims }**

Intermediaries must follow the procedures described below for medical review of dysphagia claims for SLP, OT, and PT services.

**A - Medical Work-up**

Documentation by the physician must establish a preliminary diagnosis and form the basis of estimates of progress. Patients must be selected for therapy after a proper medical diagnostic evaluation by a physician. The medical work-ups must document whether the difficulty involves the oral, pharyngeal, or esophageal phase of swallowing. This may involve collaboration with therapists or speech-language pathologists.

**B - Dysphagia Criteria - Oral, Pharyngeal, or Esophageal (upper one third) Phase of Swallowing**

Documentation must indicate the patient's level of alertness, motivation, cognition, and deglutition. In addition, at least one of the following conditions must be present:

- History of aspiration problems or aspiration pneumonia, or definite risk for aspiration, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia;

- Nasal regurgitation, choking, frequent coughing up food during swallowing, wet or gurgling voice quality after swallowing liquids or delayed or slow swallow reflex;
- Presence of oral motor disorders such as drooling, oral food retention, leakage of food or liquids placed into the mouth;
- Impaired salivary gland performance and/or presence of local structural lesions in the pharynx resulting in marked oropharyngeal swallowing difficulties;
- In-coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the buccal cavity and/or bite, chew, suck, shape and squeeze the food bolus into the upper esophagus while protecting the airway;
- Post-surgical reaction affecting ability to adequately use oropharyngeal structures used in swallowing;
- Significant weight loss directly related to non-oral nutritional intake (g-tube feeding) and reaction to textures and consistencies; or
- Existence of other conditions such as presence of tracheostomy tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis, and cricopharyngeal dysfunction.

### **C - Esophageal (lower two thirds) Phase of Swallow**

Esophageal dysphagia (lower two thirds of the esophagus) is difficulty in passing food from the esophagus to the stomach. If peristalsis is inefficient, patients may complain of food getting stuck or of having more difficulty swallowing solids than liquids. Sometimes patients experience esophageal reflux or regurgitation if they lie down too soon after meals.

Inefficient functioning of the esophagus during the esophageal phase of swallowing is a common problem in the geriatric patient. Swallowing disorders occurring only in the lower two thirds of the esophageal stage of the swallow have not generally been shown to be amenable to swallowing therapy techniques and may not be approved. An exception might be when discomfort from reflux results in food refusal. A therapeutic feeding program in conjunction with medical management may be indicated and constitute reasonable and necessary care. A reasonable and necessary assessment of function, prior to a conclusion that difficulties exist in the lower two thirds of the esophageal phase, may be approved, even when the assessment determines that skilled intervention is not appropriate.

### **D - Assessment**

Medical work-up and professional assessments must document history, current eating status, and clinical observations such as:

- Presence of a feeding tube;

- Paralysis;
- Coughing or choking;
- Oral motor structure and function;
- Oral sensitivity;
- Muscle tone;
- Cognition;
- Positioning;
- Laryngeal function;
- Oropharyngeal reflexes; and
- Swallowing function.

This information is used to determine necessity for further medical testing, e.g., videofluoroscopy, upper GI series, endoscopy. If videofluoroscopic assessment is conducted (modified barium swallow), documentation must establish that the exact diagnosis of the swallowing disorder cannot be substantiated through oral exam and there is a question as to whether aspiration is occurring. The videofluoroscopy assessment is conducted and interpreted by a radiologist with assistance and input from the physician and/or individual disciplines. The assessment and final analysis and interpretation should include a definitive diagnosis, identification of the swallowing phase(s) affected, and a recommended treatment plan. An analysis by an individual discipline may be submitted as a separate line item charge.

### **E - Care Planning**

Documentation must delineate goals and type of care planned which specifically addresses each problem identified in the assessment, such as:

- Patient care-giver training in feeding and swallowing techniques;
- Proper head and body positioning;
- Amount of intake per swallow;
- Appropriate diet;
- Means of facilitating the swallow;

- Feeding techniques and need for self help eating/feeding devices;
- Food consistencies (texture and size);
- Facilitation of more normal tone or oral facilitation techniques;
- Oromotor motor and neuromuscular facilitation exercises to improve oromotor control;
- Training in laryngeal and vocal cord adduction exercises;
- Compensatory swallowing techniques; and
- Oral sensitivity training.

As with all rehabilitation services, there must be a reasonable expectation that the patient will make material improvement within a reasonable period of time.

#### **F - Professional Services**

Services are sometimes performed by speech-language pathologists, occupational therapists and physical therapists in concert with other health professionals. Services are often performed as a team with each member performing unique roles which do not duplicate services of others. Services may include, but are not limited to, the following example.

**EXAMPLE:** One professional assisting with positioning, adaptive self help devices, inhibiting abnormal oromotor and/or postural reflexes while another professional is addressing specific exercises to improve oromotor control, determining appropriate food consistency form, assisting the patient in difficulty with muscular movements necessary to close the buccal cavity or shape food in the mouth in preparation for swallowing. Another professional might be addressing a different role, such as increasing muscle strength, sitting balance and head control.

Intermediaries medically review in accordance with general principles for coverage in MIM §§3101ff. and documentation in PIM Chapter 6 §§5ff., §6ff., and 7ff.

#### **G - Chronic Progressive Diseases**

Patients with progressive disorders, such as Parkinson's disease, Huntington's disease, Wilson's disease, multiple sclerosis, or Alzheimer's disease and related dementias, do not typically show improvement in swallowing function, but will often be helped through short-term assistance/instruction in positioning, diet, feeding modifications, and in the use of self help devices. Intermediaries medically review documentation in support of short-term assistance/teaching and establishment of a safe and effective maintenance dysphagia program.

Chronic diseases such as cerebral palsy, status post-head trauma or stroke (old) may require monitoring of swallowing function with short-term intervention for safety and/or swallowing effectiveness. Documentation should relate to either loss of function, or potential for change. As with other conditions/disorders, the reasonableness and necessity of services must be documented.

Documentation should include:

- Changes in condition or functional status;
- History and outcome of previous treatment for the same condition; and
- Other information which justifies the start of care.

### **H - Nasogastric Tube or Gastrostomy Tube**

The presence of a nasogastric or gastrostomy tube does not preclude need for treatment. Removal of a nasogastric or gastrostomy tube may be an appropriate treatment goal.

### **I - Safety**

Although the documentation must indicate appropriate treatment goals to improve a patient's swallowing function, it must also indicate that the treatment is designed to ensure that it is safe for the patient to swallow during oral feedings. Improving the patient's safety and quality of life by reduction or elimination of alternative nutritional support systems and advancement of dietary level, with improved nutritional intake should be the primary emphasis and goal of treatment. The documentation must be consistent with these goals and indicate the reasonableness and need for skilled intervention.

### **J - Skilled Level of Care**

Documentation of ongoing dysphagia treatment should support the need for skilled services such as observation, treatment, and diet modification. Documentation which is reflective of routine, repetitive observation or cuing may not qualify as skilled rehabilitation.

For example, repeated visits in which the care-giver appears only to be observing the patient eating a meal, reporting on the amount of food consumed, providing verbal reminders (e.g., slow down or cough) in the absence of other skilled assistance or observation suggests a non-skilled or maintenance level of care. Maintenance programs are covered for a brief period and are usually included during the final visits of the professional.

### **K - Professional Qualifications**

Swallowing rehabilitation is a highly specialized service. Intermediaries should assume that the professionals rendering care have the necessary specialized training and experience. They refer any suspected patterns of poor quality to the RO.

## **L - Consultation**

Intermediaries are encouraged to seek consultation/advice from the American Speech-Language-Hearing Association, American Occupational Therapy Association, and American Physical Therapy Association as these claims often require MR by therapy or speech-language pathology consultants.

### **11 - MR of Hospital Outpatient Claims {tc \11 "11 -- MR of Hospital Outpatient Claims }**

Intermediaries select outpatient claims for MR by revenue code, diagnostic code, HCPCS code, provider, or other parameter or combination of parameters. This added procedure is to be used in conjunction with the intermediary focused medical review procedures.

They determine:

- If services are reasonable and necessary;
- If services are excluded from coverage;
- If services billed were in fact furnished; and
- If all other requirements for coverage are met.

See PIM Chapter 6 §11.2ff below for the selection criteria to use in identifying outpatient claims for MR.

Intermediaries do not use these guidelines for review of physical therapy, speech pathology, or occupational therapy.

### **11.1 - Guidelines for Hospital Outpatient Services{tc \12 "11.1 -- Guidelines for Hospital Outpatient Services}**

#### **11.1.1 - Diagnostic Services{tc \13 "11.1.1 -- Diagnostic Services}**

Intermediaries evaluate the services to determine if the services are medically appropriate for the diagnosis of an illness or injury. They do not pay for routine screening tests which are excluded from coverage (e.g., routine physicals, chest X-rays).

Intermediaries consider the absence of a documented physician's order for diagnostic services only when the services are questionable. The absence of a documented physician's order is one piece of evidence to use when considering whether the services are medically necessary. For example, lack of a documented physician's order may mean that a billing error has occurred or the service was not furnished. Intermediaries do not deny a claim solely on the basis that there is no written order.

#### **11.1.2 - Therapeutic Services{tc \13 "11.1.2 -- Therapeutic Services}**

Intermediaries evaluate services which are incidental to physicians' services. Supplies and services must be furnished on a physician's order. If they believe there is reason to question whether the services were reasonable and medically necessary, the absence of a documented physician order could be one piece of evidence to consider. However, if the services do seem appropriate, they do not deny the claim merely because there is no documented order.

### **11.1.3 - Drugs and Biologicals**

Intermediaries review to determine if drugs and biologicals meet the criteria for payment. These criteria are met if the drugs:

- Are not excluded from coverage (e.g., laetrile);
- Are considered effective drugs by the FDA; and
- Are of a type which cannot be self-administered (drugs which are non-injectable are normally considered self-administered) unless they must be put directly into an item of DME or prosthetic device, or are normally self-administered but are being administered by another person in an emergency situation; e.g., the patient is in a diabetic coma.

Intermediaries review high cost drugs to determine if they were medically reasonable or necessary, e.g., Tissue Plasminogen Activator (TPA).

### **11.1.4 - Supplies**

Intermediaries review to determine if supplies meet the criteria for payment, i.e., if the amount and quantity are medically necessary and reasonable.

### **11.1.5 - Narcolepsy, Sleep Apnea, Impotence Clinics**

Intermediaries review clinic documentation for the following services:

Narcolepsy Clinic      Intermediaries determine the conditions were severe enough to interfere with the patient's well being and pay for a maximum of three sleep naps.

Sleep Apnea Clinic      Pay for a maximum of one overnight stay.

Impotency Clinic      The need for diagnostic testing and therapeutic services must be confirmed by medical evidence. Diagnostic testing that duplicates previous testing is not covered and intermediaries pay for a maximum of two nights stay.

### **11.1.6 - Education Programs**

#### **{tc \l3 "11.1.6 -- Education Programs }**

Intermediaries review to ensure that education programs are appropriate and integral parts of the covered services needed for treatment of the individual's illness or injury.

**A --** Medical documentation (beneficiary diagnose(s), complaints, or medical history) must support the need for medical education, e.g., diabetic education for a newly diagnosed diabetic.

**B --** Remedial education for a chronically ill patient who has had a change in his/her medical condition or treatment is covered only if the medical documentation supports the need.

**C --** The frequency of medical education should be medically reasonable to the goals of the program. Educational activities not closely related to the care and treatment of the patient, such as general public education on good nutrition and hygiene, are not medically reasonable or necessary.

### **11.1.7 - Observation Room Services{tc \l3 "11.1.7 -- Observation Room Services}**

Intermediaries must review to ensure that the services are reasonable and necessary.

**A -** They are covered only if they are reasonable and necessary to evaluate an outpatient's condition or to determine the need for admission. The services are also covered if they are provided on the order of a physician or other practitioner who is authorized to admit patients or to order outpatient tests.

**B -** Services provided for the patient's or the physician's convenience are not covered.

**C -** Services which are covered and paid for on another basis, such as those defined as facility services subject to the Ambulatory Surgical Center (ASC) payment rate, are not covered as observation services.

**D -** Routine preparation services prior to testing and routine post testing services are not covered.

### **11.1.8 - Outpatient Surgical Services and Ancillaries{tc \l3 "11.1.8 -- Outpatient Surgical Services and Ancillaries}**

Intermediaries ensure that the services and ancillaries are medically reasonable and necessary. (See MIM §3626.4.)

### **11.1.9 - Review of Outpatient Hospital Psychiatric Services{tc \l3 "11.1.9 -- Review of Outpatient Hospital Psychiatric Services}**

Intermediaries ensure that the psychiatric services are reasonable and necessary.

**A -** Psychiatric Coverage Criteria

Services are covered if they are prescribed by a physician and the following conditions are met:

- Individualized plan of treatment (a plan is not required for a few brief services); and
- A plan of care must include the type, amount, frequency, and duration of services, including goals and diagnoses.

**B** - Documentation includes:

Facility and patient identification	Provider name, patient name, provider number, HICN, age
Physician referral and date	Self-explanatory
Date of last certification	Self-explanatory
Diagnosis	This is the primary diagnosis for which outpatient hospital psychiatric services were rendered. Indicate other diagnoses or those that influence the primary diagnosis.
Duration	The total length of time the services have been rendered (in days) from the date initiated. Includes the last day in the current billing period.
Number of visits	The total number of patient visits completed since services were initiated. Includes the last visit in the billing period.
Date of onset	The date of the primary diagnosis.
Date treatment started	The date services were initiated.
Billing period	When services began and ended in the billing period (from – through dates).
Medical history	Should include a brief description of the patient's psycho-functional status prior to the onset of the condition requiring services and any pertinent history prior to treatment.
Initial evaluation and date	The initial evaluation performed at the facility.
Plan of treatment	Should include specific goals and a reasonable estimate of when they are

and date  
established

expected to be reached (e.g., 3-6 months). Includes specific therapies, e.g., creative art, music, movement, recreation therapy. Services must be prescribed by a physician and be individualized. There is no requirement that the physician who establishes or certifies the plan of care (POC) be the one who reviews the plan.

Physician Progress  
notes

Should provide information on periodic evaluations, consultations, conferences with staff, and patient interviews. Notes should include diagnoses, an estimate of the duration of treatment and a description of how treatment goals are being realized and as well as POC changes.

Medical record  
notes

Should include a discussion of the individual's symptoms and present behavior, for example:

- Thoughts - disturbance in orientation to person, place, and time; retarded thought processes; impaired ability to process incoming information; blocking of thoughts; autistic thinking; suspiciousness, distorted, illogical thinking; fears etc.
- Perception - appearance of listening to voices with inappropriate effect, etc.
- Anxiety - intense apprehension, palpitations, chest discomfort, obsessive compulsive behavior, etc.
- Activity - withdrawal from relationships and contact with others; impairment in goal-directed activity; purposeless movement such as pacing and mannerism; unpredictable behavior that may be related to delusions or hallucinations; impairment or absence of social skills; poor work history or hyperactivity.
- Self care - neglectfulness; lack of motivation; impairment in bathing, grooming, etc.
- Nutrition - unawareness of hunger or thirst; apathy to food at mealtime; fear of eating, etc.
- Sleep -disturbed sleep patterns; reluctance to go to bed at night or inability to awaken in morning, etc.
- Family processes - demeaning of family with anger and blame, family conflicts and instability; etc.

Medical documentation may include, but is not limited to, daily outpatient logs, activity checklists, case management, nurse's, therapist's, and physician's notes. Documentation should include medication changes as well as therapy changes.

Frequency and Duration There are no specific time limits. Medical documentation should support the frequency and duration of services provided. When considering reducing the frequency of the services provided, consider how their reduction may lead to relapse or re-hospitalization.

Goals Should describe the control of symptoms and how they will maintain behavioral/functional levels.

- Need not be restorative;
- Should be reasonable and relate to the individual's treatment need; and
- Diagnostic studies should relate to the individual's treatment needs.

**NOTE:** Improvement is measured by comparing the effect of continuing treatment versus discontinuing it. Do not deny services because a therapeutic condition has stabilized or because treatment is primarily for maintaining the present level of functioning.

Intermediaries determine when it is established that the coverage criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment.

### **C - Partial Hospitalization Services**

Partial hospitalization encompasses a variety of outpatient psychiatric programs each of which can vary in its function, the population served, the treatment goals, and the services provided. Partial hospitalization programs must meet the documentation criteria outlined in MIM §3112.7(C). Intermediaries review all services and procedures to determine whether a particular type of group of services/activities are medically reasonable and necessary and meet the coverage requirements. The following are usually part of a partial hospitalization program:

- Individual and group therapy under the direction of physicians, psychologists or other mental health professionals authorized by the State;
- Services of social workers or trained psychiatric nurses and other staff trained to work with psychiatric patients;
- Drugs and biologicals furnished to outpatients for therapeutic purposes, but billable only if they cannot be self-administered;

- Family counseling services only where the primary purpose is for the treatment of the patient's condition. (See Coverage Issues Manual §35-14.);
- Patient education programs only where the educational activities are closely related to the patient's care and treatment. (See Coverage Issues Manual §80-1.); and
- Diagnostic services tests used to diagnose or to determine a treatment plan.

Intermediaries review specialized therapies such as creative art therapy, music therapy, movement therapy, and recreation therapy to determine if the overall benefits are appropriate to the treatment and goals prescribed. (Occupational therapy must be reviewed using the criteria in PIM Chapter 6, §7.)

#### **D - Non-covered Services.**

The following services are not covered:

- Meals and transportation;
- Activity therapies, group activities or other services and programs which are primarily recreational or diversional in nature;
- Day treatment programs often referred to as "geriatric day care" that consist entirely of activity therapies are not covered. These services provide social and recreational activities to individuals who need some supervision during the day while family members are away from home. Such programs are not reasonable and necessary and do not have physician involvement;
- Psycho-social programs which are community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction. If an individual's outpatient hospital program consists entirely of psycho-social activities, it is not covered. Partial hospitalization programs may include some psycho-social components and to the extent they are **not** primarily for social or recreational purposes, they are covered; and
- Vocational training which may include vocational and prevocational assessment and training. Services related **solely** to specific employment opportunities, work skills or work settings are not covered.

#### **E - Biofeedback Therapy**

Biofeedback therapy is covered under Medicare only when it is reasonable and necessary for the re-education of specific muscle groups or treatment of pathological muscle abnormalities of incapacitating muscle spasm or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have been unsuccessful. It is not a covered treatment of ordinary muscle tension states or for psychosomatic conditions.

## **F - Chemical Dependency**

Diagnostic and therapeutic services for alcohol and/or drug dependency are covered. Intermediaries review diagnostic services and therapeutic services to ensure that they are reasonable and necessary for the treatment of the drug dependency problem.

## **G - Family Counseling**

Family counseling services are covered only where the primary purpose of the counseling is the treatment of the patient's condition; that is, when there is a need to observe the patient's interaction with family members or to assess the capability of family members to aid in the patient's rehabilitation.

Family counseling services that are primarily directed toward the treatment of a family member's problem with respect to the patient's condition are not covered.

## **11.2 - Hospital Outpatient MR Selection Criteria**

The selection criteria below does not apply to physical therapy, speech pathology, occupational therapy, or ESRD services furnished on an outpatient basis. See PIM Chapter 6 §§5ff, 6ff, and 7ff respectively for their review criteria.

### **11.2.1 - Required Reviews**

The following are required of the intermediary:

- Determine if services billed by a non-hospice provider during a period of hospice election are related to the terminal illness. Identify these claims by the Z trailer in the query reply or by CWF hospice reject or alert codes.
- Automatically deny CWF rejects. They do not require MR.
- Review claims (other than CWF rejects) to determine if the outpatient hospital services are related to the individual's terminal illness.
- Request medical records only when you cannot make a determination as to whether or not the services provided were related to the individual's terminal illness. (Obtain medical information from the hospital.) NOTE: Many illnesses are brought on by the underlying condition of the terminally ill patient. For example, it is not unusual for a terminally ill patient to develop pneumonia because of the weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient is treatment of a related condition. Deny services related to the terminal illness. Pay services which are unrelated to the terminal illness.
- Ensure that excluded services identifiable through diagnostic codes, HCPCS, or revenue codes are not paid. Where it is obvious from the code alone that the services

are non-covered, the identification and denial of the service is a claims processing function. The review becomes medical review when, for example, an otherwise excluded service can be covered in conjunction with other diagnoses or conditions and medical staff review is required to determine if conditions for coverage are met.

### **11.2.2 - Review Guides**

Intermediaries select additional services for review based on knowledge of problem areas and the focused MR analysis. They may direct the review to certain providers. They are responsible for analysis of data to ensure that the review is effective and for modifying its parameters based upon analysis. The following services have been identified as high volume, high cost, high potential of being non-covered. Intermediaries base the selection of any of these services upon analysis of data and experience regarding the potential for non-covered care and cost effectiveness of review.

#### **A - Medical Documentation**

Once a claim has been selected for MR, it is expected that sufficient documentation will be available to allow a medical necessity and coverage decision. If such a judgement can be made on the basis of information found on the bill, intermediaries review the bill(s) at level one using automated screens or clerks with appropriate parameters.

### **11.2.3 - Revenue Code MR**

The following revenue codes are high volume, high cost or have a high potential of being non-covered.

Diagnostic Services	321 Angiocardiology,
	324 - Chest X-Ray,
	350 - CAT Scans,
	351 - Head Scans,
	359 - Other CT Scans,
	610 - MRI,
	611 - Brain/Brainstem,
	612 - Spinal Cord/Spine,
	730 - EKG General,
	732 - Telemetry,
	739 - Other EKG/ECG,
	920 - Other DX SVS,
	921 - Peripheral Vascular Lab,
	922 - EMG,
	925 - Pregnancy Test,
	929 - Other Diagnostic Service

Psychiatric	<ul style="list-style-type: none"> <li>900 - General,</li> <li>901 - Electroschock,</li> <li>902 - Milieu Therapy,</li> <li>903 - Playtherapy,</li> <li>909 - Other,</li> <li>910 – General,</li> <li>911 - Rehabilitation,</li> <li>912 - Day Care,</li> <li>913 – Night Care,</li> <li>914 – Individual Therapy,</li> <li>915 – Group Therapy,</li> <li>916 - Family Therapy,</li> <li>917 - Bio Feedback,</li> <li>918 – Testing,</li> <li>919 – Other</li> </ul>
Supplies	<ul style="list-style-type: none"> <li>270 - General,</li> <li>271 - Nonsterile Supplies,</li> <li>272 - Sterile Supplies,</li> <li>273 - Take Home Supplies,</li> <li>274 – Prosthetic Devices,</li> <li>275 – Pacemaker,</li> <li>278 - Oxygen – Take Home,</li> <li>279 - Other Devices</li> </ul>
Audiology	<ul style="list-style-type: none"> <li>470 - General,</li> <li>471 - Diagnostic,</li> <li>472 - Treatment,</li> <li>479 – Audiology</li> </ul>
Clinic	<ul style="list-style-type: none"> <li>510 - General,</li> <li>511 - Chronic Pain Center,</li> <li>512 - Dental Clinic,</li> <li>519 - Other Clinic</li> </ul>
Ambulance	<ul style="list-style-type: none"> <li>540 - General,</li> <li>531 - Supplies,</li> <li>542 – Medical Transport,</li> </ul>

543 - Heart Mobile,  
544 - Oxygen,  
545 - Air Ambulance,  
546 - Neo-natal Ambulance,  
549 - Other Ambulance

#### **11.2.4 - MR of Questionable Diagnoses and Procedures**

<u>HCPCS Code</u>	<u>ICD9CM Code &amp; Description</u>
17999	86.99 Other operations on skin and subcutaneous tissue
17380	86.92 Electrolysis and epilation of skin
	388.9 Unspecified disorder of the ear
70300	87.12 Radiologic examination teeth; single view
70310	87.12 Partial examination, less than full mouth
70320	87.11 Complete, full mouth
	V72.1 Examination of ears and hearing
	520.0-521.9 Disorders of tooth development and eruption
	522.0-523.8 Diseases of Pulp and periapical tissues
	523.9 Unspecified Gingival and Periodontal diseases
	526.5 Aveolites of jaw
	526.81-526.89 Other specified disease of the jaw
	526.9 Unspecified disease of the jaws
	524.0-524.6,524.8 Dentofacial anomalies, including malocclusion
	524.9 Unspecified dentofacial anomalies

V03.0-V06.9 Prophylactic vaccination and inoculation

V72.0-72.9 Special investigations and examinations (except V72.5 Radiology exam and V72.6 laboratory exam, which will be the first reported code on all visits when the patient comes in just for x-rays or lab work). (This code should be accompanied by an additional diagnosis).

89.31 Dental examinations

92599 93.75 Melodic intonation therapy

V25.2 Sterilization

### **11.2.5 - Diagnosis and Procedure Codes that may be Automatically Denied{tc \13 "11.2.5 - - Diagnosis and Procedure Codes that may be Automatically Denied}**

The following diagnosis and procedure codes may be denied automatically by the intermediary, if the service, in conjunction with the diagnosis on the claim, is always excluded e.g., only DX is dental caries with extraction of tooth and the non-covered service(s) is the only service on the claim. Intermediaries must advise providers of automatic denials and allow enough time for providers to correct any incorrect coding problems.

HCPCS ICD9CM Code & Description  
Code

99.92 Other Acupuncture

15824 86.82 Rhytidectomy; forehead

15825 86.82 Neck with platysmal tightening (platysmal flap, "P-flap")

15826 86.82 Glabellar frown lines

15828 86.82 Check, chin, and neck

15829 86.82 Subcutaneous musculoaponeurotic system (SMAS) flap

78351 88.98 Dual Photon Absorptiometry

- 77600 Hyperthermia for treatment of cancer. Hyperthermia, externally generated; superficial (i.e., heating to a depth of 4cm or less)
- 77605 Deep (i.e., heating to depths greater than 4)
- 77610 Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
- 77615 More than 5 interstitial applicators
- 77620 Hyperthermia generated by intracavitary probe(s) (Use the ICD-9-CM diagnostic listing to identify neoplasms which may be treated by hyperthermia.)

93.35 Hyperthermia NEC (other heat therapy)

V70.0 Routine general medical examination at a health care facility

V70.3 Other medical examination for administrative purposes

V70.5 Health examination of defined subpopulations

V70.7 Examination for normal comparison or control in clinical research

V70.9 Unspecified general medical examination

- 92590 V53.2 Fitting and adjustment of other device: hearing aid

- 92593 V53.1 Fitting and adjustment of other devices: spectacles and contact lens

V52.3 Fitting of denture prosthetic device

23.42 Removal and restoration of teeth: insertion of fixed bridge

23.0 Forceps extraction of tooth  
 23.01 Extraction of deciduous tooth  
 23.09 Extraction of other tooth

23.1 Surgical removal of tooth  
 23.11 Removal of residual root  
 23.19 Other surgical extraction of tooth

23.2 Restoration of tooth by filling

23.3 Restoration of tooth by inlay

23.43 Insertion of removable bridge

23.4 Other dental restoration  
23.41 Application of crown  
23.42 (above)  
23.43 (above)  
23.49 Other

V50.0-V50.3

V50.8-V50.9 Elective surgery for purposes other than remedying health states

## **12 - MR of Ambulance Services**

### **A - Ambulance**

Intermediaries review to determine if services meet the criteria in MIM §3114.

They:

- Determine if the patient's condition was such that another method of transportation was contraindicated; and
- Determine if non-reusable equipment/supplies used for patient care during transport were reasonable and necessary.

Medically necessary transport by ambulance may include:

- Emergency situations, e.g., accidents, injury, acute illness;
- Need for restraints;
- Unconscious or in shock;
- Required emergency treatment during the trip;
- Required immobilization, i.e., fracture or the possibility of a fracture;
- Sustained acute stroke or myocardial infarction; or
- Experiencing severe hemorrhage.

A beneficiary who was pronounced dead while enroute to, or upon arrival at, the hospital by ambulance is covered. Transportation of a beneficiary who was pronounced dead by a legally authorized individual before the ambulance was called is not covered. (See MIM §3114.)

### **B - Air Ambulance**

Intermediaries review to determine the necessity of air ambulance services in MIM §3114C.11:

- Was the point of pickup inaccessible to land ambulance?
- Did weather, or traffic conditions, etc., make pickup by land ambulance impractical, impossible, or overly time consuming?
- Was the patient's condition such that the length of time required by the land ambulance would have endangered the patient's life or health, e.g., a 30-60 minute trip by land ambulance for an unstable cardiac patient?

**NOTE:** Payment of land rate rather than air rate is a reduction in reasonable cost, not a §1862(a)(1)(A) denial.

### **13 - MR of EPO Therapy for HIV-Infected Patients{tc \11 "13 -- MR of Epoetin (EPO) Therapy for HIV-Infected Patients}**

Medicare will cover EPO therapy for the treatment of anemia related to therapy with Zidovudine (AZT) in HIV-infected patients. All claims submitted under these conditions should contain the appropriate diagnosis in the series 042 through 044, Human Immunodeficiency Virus Infection, **and** 285.8, Other specified anemias, or 285.9, Anemia unspecified.

However, the absence of either of the specified anemia codes does not preclude coverage for the drug. Intermediaries extend coverage to additional anemia diagnoses on the advice of the intermediary medical consultant provided the treatment is determined to be reasonable and necessary for the condition.

### **14 B Intermediary Review of CWF Alerts{tc \11 "14 B Intermediary Review of Common Working File (CWF) Alerts}**

#### **A B General**

The following identify MR procedures for the review of claim alerts referred to MR staff by CWF edits. Intermediaries perform MRs of these alerts as part of FMR. They should **be aware of patterns involving the same provider(s)**. Cases that need referral to the RO or to the program integrity staff should be identified as part of the review. Reviews must be coordinated with carriers and other servicing FIs as necessary. It is not intended that the intermediary medically review every alert. However, a sufficient number of each category must be reviewed to determine if there are provider problems, possible abuse, or errors resulting in significant overpayments. The review of alerts should be a part of the intermediary data collection and analysis. If problems are detected, intermediaries should establish system edits or clerical review parameters wherever possible.

#### **B B Alert 7108**

A bill has been processed for therapy services (i.e., same revenue and/or HCPCS code) for this beneficiary with the same or overlapping service dates from the same or another provider, physician or independent therapist.

**Purpose:** To detect inappropriate utilization of therapy services.

- Intermediaries should detect duplicates that should be resolved in claims processing. The following are examples of situations which might result in this edit:
- The patient was transferred from one provider to another;
- Equipment was required that could not be provided by one of the providers;
- One carrier bill was for a physician evaluation and the other for therapy services needed and provided by the therapist;
- Duplicate services being provided by unrelated entities; or,
- Duplicate services or duplicate billing by related entities (e.g., therapy is billed by a rehabilitation agency and by the therapist to the carrier).

**Action:** Intermediaries must make decisions on the information obtained from the provider they service. However, where a pattern of questionable practices has been identified involving providers serviced by another intermediary or carrier, they must coordinate the review.

Intermediaries must track the providers involved and if a pattern evolves with the same providers, review those providers' claims.

If the alerted claim is determined to be noncovered, they forward an adjustment to CWF and recover the overpayment.

Intermediaries must notify providers of problems of which they may be unaware, e.g., beneficiary receiving therapy services from multiple sources.

Also they refer potential fraud or program integrity cases to the RO.

### **C B Alert 7530**

A beneficiary receives identical services from 3 or more different providers with less than 30 day intervals between billing dates. This alert will be generated when this occurs on outpatient hospital, other Part B outpatient services and rehab/CORF billings.

**Purpose:** To detect inappropriate utilization by beneficiaries.

**Action:** If the same intermediary is for two or more of the providers, and it can be determined from the coding on the bill that the services are not duplicated, no further action is necessary.

The claim would be reviewed only if it would normally be selected by your focused review criteria.

If the services appear to be duplicated, intermediaries request the medical documentation from all providers involved. They deny medically unnecessary or unreasonable services and alert the RO and providers if beneficiaries are identified who are "provider hopping" to receive unnecessary services.

If the intermediary is not the same for the other providers involved, they coordinate review with the other intermediaries involved and take the appropriate action.

When alerted or other processed claims are determined to be noncovered, they process adjustments to CWF and they recover overpayments.

### **D B Alert 7532**

The same provider bills outpatient services monthly or more frequently for the same beneficiary for a period of 6 months or more. This alert is applicable for outpatient, rehabilitation/CORF and RHC billing for clinic visits, therapy, psychiatric and other therapeutic services.

**Purpose:** To detect overutilization of services.

Where intermediary data analysis shows a provider has longer periods of utilization of services than those in its peer group, this alert will identify bills with lengthy utilization. In addition, intermediaries must analyze the alerts to identify providers who appear significantly more than others.

**Action:** Intermediaries must medically review for medical necessity those claims which, based on the diagnosis and/or services furnished, or on prior experience, would not be expected to continue for 6 months or more. They review claims from providers identified for focused review.

They forward denials for adjustment to CWF and they recover an overpayment.

#### **E B Alert 7534**

An outpatient hospital bill (bill type 13x) with cardiac rehabilitation revenue code (943) has charges for repeat cardiovascular stress testing (HCPCS code 93015, 93017, and/or 93018) in a period of less than 90 days since prior testing.

**Purpose:** To detect billing for cardiac rehabilitation where stress testing is performed more frequently than allowed by coverage guidelines.

**Action:** Normally, intermediaries allow one stress test at the beginning of the program and another after 3 months (usually after the end of the program). Based upon review of the medical record documentation, intermediaries must ensure that:

- There is a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; or coronary bypass surgery; and/or stable angina pectoris;
- The reason(s) for the additional stress test is specifically documented. If documentation is incomplete, request the reason(s) from the provider or beneficiary's attending physician; and
- The stress test is reasonable and necessary based upon the patient's diagnosis and medical condition.

If stress testing is determined reasonable, intermediaries should process the claim. If the stress testing is determined not to be reasonable, they deny the charges, recover the inappropriate payment and process an adjustment to CWF.

#### **F B Alert 7535**

A hospital outpatient bill is for the same beneficiary and same service as a denied physician service. The service dates are the same or overlapping.

**Purpose:** To detect medically unnecessary provider billed services when the related physician's component has been denied.

**Action:** Intermediaries must review at least a sample of these claims until it is determined that the provider services are coverable. If a pattern is detected where a certain provider's claims always appear in conjunction with denied physician's services, they continue review for this provider. Other actions may also be required such as coordination with the carrier, an audit of the provider, notification to the RO of potential abuse, etc.

Based upon a review of the medical record documentation, intermediaries must ensure that:

- The hospital provider component outpatient bill was for a clearly covered service; and
- The type of provider component service rendered was reasonable and necessary, based upon the beneficiary's medical condition, orders, and patient assessment.
- If the alerted claim is subsequently denied, intermediaries recover the erroneous payment and process an adjustment to the CWF.

#### **G - Alert 8100**

An inpatient claim, (11x), outpatient claim (13x) or ASC claim (83x) for the same beneficiary having the same surgical procedure performed on different days of service in the same or different place of service. The surgical procedures are appendectomy, splenectomy, total hysterectomy, tonsillectomy, thyroidectomy, parathyroidectomy and prostatectomy.

**Purpose:** To detect duplicate billings for surgical procedures that are one-time procedures.

**Action:** Intermediaries review for coding errors at the claims or nonprofessional review level.

If there are no coding errors, intermediaries must request the medical documentation for the alerted claim. The reviewer should determine that the procedure was actually performed and was reasonable and necessary. Questionable cases must be referred to the PRO where applicable.

Where the procedure on the alerted claim is correct, intermediaries must review earlier processed claims for errors. If necessary, they alert the other FI involved to conduct this review. They must take whatever corrective actions are necessary. If processed claims are denied, they forward an adjustment to CWF and recover the overpayment.

If the alerted claim is subsequently denied, intermediaries recover the erroneous payment and process an adjustment to the CWF. If the claim is correct but a prior claim is in error, they adjust the prior claim or contact the appropriate servicing intermediary to take appropriate action on the prior claim.

#### **H - Alert 8101**

An inpatient (11x), outpatient (13x), or ASC (83x) bill type for a cataract extraction was reported twice for the same beneficiary. Intermediaries must perform medical review on a sample of these alerts until it is determined that no problems exist. They must be aware of the same provider(s) appearing frequently.

**Purpose:** To detect billings for surgical procedures that are unnecessary bilateral procedures that were previously provided.

**Action:** Based upon a review of the medical record documentation, intermediaries must ensure that the repeat cataract extraction performed was reasonable and necessary based upon the medical condition of the beneficiary. Questionable cases must be referred to the PRO where applicable.

If the documentation does not show this procedure to be a repeat procedure, intermediaries review the earliest processed claim for error or contact the servicing FI to conduct this review.

If the alerted claim or earlier processed claim is subsequently denied, intermediaries recover the erroneous payment and process an adjustment to the CWF.

## **15 -MR of Partial Hospitalization Claims**

### **15.1 - General**

Effective immediately the following medical review instructions will be in place for all FIs for all types of review for partial hospitalization claims. HCFA's policy is based on the following citations:

The Act, §1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

The Act, §1861(ff) and 1832 (a) define the partial hospitalization benefit and provide for coverage of partial hospitalization in a hospital or CMHC setting.

The Act, §1861(s)(2)(B) references partial hospitalization in a hospital setting.

The Act, §1835 (a)(2)(F) references physician certification and plan of care.

The Act, §1833(e) requires services to be documented in order for payment to be made.

42 CFR 410.43, 410.110 and 424.24(e) set forth the conditions and exclusions for the partial hospitalization benefit.

HCFA Ruling 97-1 clarifies Limitation on Liability rules for appeals.

### **15.2 - Bill Review Requirements**

FIs must conduct review of partial hospitalization bills in accordance with applicable MIM sections. For partial hospitalization services provided by CMHCs see MIM §3651, §3604 (except §3651.C). FI standard operating procedure for soliciting additional documentation, claim adjudication, and recoupment of overpayment. The following components should be used to help determine whether the services provided were accurate and appropriate.

#### **A - Initial Psychiatric Evaluation/Certification**

Upon admission, a certification by the physician must be made that the patient admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

### **B - Physician Recertification Requirements**

1. **Signature** - The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.
2. **Timing** - The first recertification is required as of the 18th calendar day following admission to the partial hospitalization program. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
3. **Content** - The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:
  - The patient's response to the therapeutic interventions provided by the partial hospitalization program;
  - The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and
  - Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program.

### **C - Treatment Plan**

Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

### **D - Progress Notes**

Section 1833(e) of the Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan.

### **15.3 - Bill Review Process**

For all selected claims, review medical documentation and determine whether the services provided were covered. The reviewer should apply the criteria in the following order (e.g., benefit category requirements, statutory exclusion from coverage, then reasonable and necessary) when making a payment determination. In order to be covered, a service must meet all three of the following criteria.

#### **A - Make A Benefit Category Determination**

Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a partial hospitalization program must be under the care of a physician who certifies the need for partial hospitalization. The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature.

Patients meeting benefit category requirements for Medicare coverage of a partial hospitalization program comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care there must be evidence of the need for the acute, intense, structured combination of services provided by a partial hospitalization program. Recertification must address the continuing serious nature of the patient's psychiatric condition requiring active treatment in a partial hospitalization program.

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations which ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

### **B - Determine Services Are Not Statutorily Excluded From Coverage**

Determine whether the services are excluded from coverage under any provision in §1862(a) of the Act. Items and services that can be included as part of the structured, multimodal active treatment program, identified in §1861(ff)(2) include:

1. Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors).
2. Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual.
3. Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients.
4. Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29).
5. Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals.
6. Family counseling services for which the primary purpose is the treatment of the patient's condition.
7. Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition.
8. Medically necessary diagnostic services.

Partial hospitalization services which make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a partial hospitalization program. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services provided in a partial hospitalization program. It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

## **C - Determine Services Provided Are Reasonable and Necessary**

This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual's condition and prevent relapse, may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g. intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Patients admitted to a partial hospitalization program do not require 24-hour per day supervision as provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the partial hospitalization program. Patients admitted to a partial hospitalization program generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association, which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Patients in partial hospitalization programs may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

### **15.4 - Reasons for Denial**

**A** - Examples of benefit category denials based on §1861(ff) or §1835(a)(2)(F) of the Act, for partial hospitalization services generally include:

- Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;
- Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g. day care programs for the chronically mentally ill; or
- Patients who are otherwise psychiatrically stable or require medication management only.

Benefit category denials made under §1861(ff) or §1835(a)(2)(F) are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

**B** - The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Act:

- Services to hospital inpatients;
- Meals, self-administered medications, transportation; and
- Vocational training.

Coverage denials made under §1861(ff) are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

**C** - The following examples represent reasonable and necessary denials for partial hospitalization services and coverage is excluded under §1862(a)(1)(A) of the Social Security Act:

- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a partial hospitalization program; or
- Treatment of chronic conditions without acute exacerbation of symptoms which place the individual at risk of relapse or hospitalization.

Reasonable and necessary denials based on §1862(a)(1)(A) are appealable and the Limitation on Liability provision does apply.

# Medicare Program Integrity Manual

## Chapter 7 - MR and BI Reports

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## **1 - Medicare Focused Medical Review Status Report (MFSR){tc \l1 "1 -- Medicare Focus Medical Review Status Report (MFSR)}**

MFSR is a management report that allows HCFA to monitor the services being targeted for investigation and correction by carriers and the success of corrective actions being employed to address those areas. Carriers can determine to focus efforts on specific services for a number of reasons as explained in the PIM Chapter 2, Section 2. The MFSR collects the following kinds of information:

- Identification of aberrant providers selected to target for corrective action in a given fiscal year (FY);
- Sources of data which contributed to identification and selection;
- Cause of problem;
- Corrective action; and
- Outcomes of corrective action.

For a given FY, carriers report on the identified areas of abuse 3 times (i.e., the initial submission, the follow-up submission, and the final submission). Follow-up information indicates whether corrective actions taken were effective in resolving the areas of abuse.

Carriers are required to submit the initial FY MFSR 1 month following the end of the FY. They update the MFSR at 12 months following the FY. A final MFSR update must be submitted 24 months following the end of the FY.

## **2 - Program Integrity Management Reports (PIMR){tc \l1 "2 -- Provider Tracking System (PTS)}**

Reserved for future use.

## **3 B Medicare Fraud Unit Quarterly Status Report {tc \l1 "3 B Medicare Fraud Unit Quarterly Status Report }**

The fraud unit documents the activities it performs and reports them to HCFA using the CROWD system detailed in Part 3 §3898.5 of the Medicare Intermediary Manual. The fraud unit must maintain data on the following topics:

- Complaints (volume, source, processing times, dispositions);
- Volume and kinds of referrals to OI;
- Networking activities; and

- Types of fraud or abuse identified and corrective actions taken, including administrative actions.

#### **4 B FID{tc \l1 "4 B Fraud Investigation Database (FID)}**

The FID will capture information on current cases that have been referred to the OIG. The FID will also report other pertinent information. Some examples of the types of data included in the FID are:

- Subject of an investigation (i.e., hospital, SNF, HHA, CORF, etc.);
- Allegation information/nature of the scheme;
- Status of the case;
- Disposition of a case (i.e., administrative action, prosecution, exclusion, settlement, etc.); and
- Contact person.

The FID will also have monitoring/reporting capabilities such as:

- The number of cases by subject, sub-subject, region, contractor, HCPCS code, etc.;
- Timely suspensions;
- Length of time to close out a case;
- Number of cases referred to OIG/FBI;
- Number of cases accepted by OIG/FBI;
- Number of cases sent back for additional development; and
- Dollar amount recovered through settlement, suspensions, recoveries other than case settlements.

#### **5 - Quarterly Carrier MR Savings Report {tc \l1 "5 -- Quarterly Carrier MR Savings Report }**

Carriers must at the end of each quarter, prepare, and submit the carrier MR savings report to HCFA. A separate report is prepared for each carrier office that receives a separate budget allocation from HCFA (does not apply to home offices).

##### **5.1 - Purpose and Scope {tc \l2 "5.1 -- Purpose and Scope }**

The quarterly carrier MR savings report is the primary source of current information about the carrier's program savings from MR activities and the cost benefit ratios resulting from review activities.

The data are used by HCFA for:

- Preparing reports about the costs and savings for Part B MR;
- Serving as a source for contractor evaluations;
- Identifying effective prepayment screens;
- Comparing the performance of individual carriers;
- Identifying problem areas for resolution; and
- Measuring trends in pre-payment and post-payment activities.

## **5.2 - Submission to HCFA {tc \l2 "5.2 -- Submission to HCFA }**

The "Carrier MR Savings Report" is completed quarterly. The report must be entered into the HCFA database within 45 days of the end of the fiscal year quarter. In addition, carriers send a copy directly to the RO and send the hard-copy original and any attachments to:

Health Care Financing Administration  
Program Integrity Group  
Mail Stop: C3-02-16  
7500 Security Blvd.  
Baltimore, MD 21244-1850

## **5.3 - Completing the Carrier MR Savings Report {tc \l2 "5.3 -- Completing the Carrier MR Savings Report }**

### **A - Page One - Quarterly MR Savings Data**

- Contractor Number - The carrier identification number HCFA has assigned to the locality.
- Contractor Name - Carrier corporate name.
- Fiscal Quarter and Year - Quarter 01, 02, 03, or 04 and the FY.
- Contact Name - The name of an individual who can answer questions concerning the information on the report.
- Contact Phone - The contact's phone number.

- Extension - Contact's phone extension number.
- Prepayment Cost - Total administrative cost of the carrier's prepayment activities funded by line 5 of the budget this quarter.
- Postpayment Cost - Total administrative cost of the carrier's postpayment activities funded by line 5 of the budget this quarter.
- HCFA 1565A, line A1 - The total of line A1 entries for this quarter.
- HCFA 1565, line 11 - The total of line 11 entries for this quarter.
- HCFA 1565A, line A3 - The total of line A3 entries for this quarter.
- I Dollars Den/Red - Net category I savings.
- I Claims Den/Red - The number of claims denied or reduced through category I screens.
- I Services Den/Red - The number of services denied or reduced through category I screens.
- Hardcopy Sent - Whether a copy of the report or supplemental report information have been sent to HCFA. Enter Y (yes) or N (no).
- Category II Screens - The number of local category II screens in operation.
- Physicians/Suppliers - The number of physicians/suppliers who generated one or more assigned or unassigned claims during the prior year.
- Remarks - Carriers enter any offset claimed. They indicate the reason and explain any abnormalities in the report.

**B - Pages Two and Three: Category II Mandated Screen**

- SCRN - The identification number of the mandated screen being reported. Ten screens may be entered on each page. (See MCM §7529.1-.20.)
- SUSPENSIONS # Claims - The number of claims edited for review by this screen during the quarter.
- SUSPENSIONS # Services - The number of services medically reviewed on the edited claims.
- SUSPENSIONS Gross \$ - The monetary value of the services reviewed. Show whole dollar amounts; round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.

- DENIED/REDUCED # Services - The number of suspended services that were denied or reduced when reviewed.
- DENIED/REDUCED Gross \$ - The monetary value of the services denied and the gross value of the reductions. Round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.
- REVERSALS # Services - The number of services denied or reduced under this screen that were reversed on appeal during the quarter being reported.
- REVERSALS Gross \$ - The monetary value of the reversals. Round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.
- TOTS - The totals will be calculated by the automated system. Carriers do not enter data on this line.

### **C - Pages Four and Five - Category II Local Screen**

Column headings and definitions correspond to those in PIM Chapter 7 §5.3 subsection B. Carriers must show the top 20 local screen identification numbers in the "SCRN" column (10 screens on each page). The "top 20" will generally fluctuate between quarters. They round all cents to the nearest dollar for entry and use gross values that have not been adjusted for reasonable charge or coinsurance. The system will calculate those reductions. They enter these screens in descending order with the screen with the highest "Denied/Reduced Gross \$" listed first.

AOLS - Carriers enter the column totals of those local screens not included in the top 20.

### **D - Page Six: Category III and Postpayment**

- Overpayments Est in Qtr - The total value of all overpayments identified as a result of activities funded through line 5 of the budget.
- Claims Suspended - Number of claims edited due to category III screens.
- Services Suspended - Number of services suspended as a result of Category III screens.
- Value of Service Sus - The dollar value of all services edited from routine processing for Category III review. Carriers round cents to nearest dollar. They do not adjust for reasonable charge or coinsurance reductions.
- Services Denied/Reduced - Number of services denied or reduced as a result of Category III screens.
- Denied/Reduced Dollars - Gross dollar amount of the Category III services denied or the amount of the reduction. Carriers round cents to nearest dollar. They do not make

reasonable charge or coinsurance adjustments.

- # Flagged Phys/Suppliers - The number of physicians and suppliers flagged for Category III review.
- Overpayments Recovered - Overpayments recovered as a result of activities funded through line 5 of the carrier budget.
- Closed Cases - The number of comprehensive reviews completed during the quarter (do not include program integrity reviews).
- Pending Cases - The number of comprehensive reviews pending at the end of the quarter (do not include program integrity reviews).
- Manually Reviewed Claims - The number of claims manually reviewed during comprehensive reviews this quarter.
- Cases Referred to OIG - The number of cases referred to OIG.
- Cases Returned by OIG - The number of cases returned by OIG for final administrative action.
- Sanctions Effectuated - The number of physicians/suppliers sanctioned upon receipt of an OIG sanction notice during the quarter as a result of activities funded through line 5 of the budget.
- CMP Cases Effectuated - The number of CMPs levied upon receipt of an OIG CMP notice during the quarter.
- Sav Cred MR Sanctions - The savings attributed to sanctions during the quarter. Carriers send documentation to HCFA substantiating the credit claimed.
- Sav Cred CMP Cases - The savings attributed to CMP cases during the quarter. Carriers send documentation to HCFA substantiating the credit claimed.

## **6 - Quarterly Intermediary MR Savings Report {tc \l1 "6 -- Quarterly Intermediary MR Savings Report }**

These revised reports replace all prior quarterly MR savings reports for hospice, SNF, HHA, OPT/CORF and ESRD facilities

### **6.1 - Submission {tc \l2 "6.1 -- Submission }**

The intermediary completes the savings report for each calendar quarter and submits electronically through the Part A Medical Review System within 30 days of the end of the reporting quarter along with the RBS to the HCFA data center. (See Screens 6 and 7.) It does not

submit the reports by hard copy. (See §2301.3 of Intermediary Manual, Part 2.) It also submits a copy to the RO.

## **6.2 - Completing the Quarterly Intermediary MR Activity Report**

The intermediary enters data in columns provided for each category of provider claims. (See Screens 6 and 7.)

### **6.2.1 - Screen 6**

#### **A - Hospice Claims**

- Number of hospice bills denied; and
- Number of hospice bills charged to lesser level (e.g., inpatient respite care changed to routine home care rate).

#### **B - ESRD Claims**

- Number of ESRD bills denied for medical necessity; and
- Number of ESRD claims denied because the services should have been included in composite rate.

#### **C - SNF Continued Stay Denials**

- Number of SNF bills reviewed; and
- Number of SNF bills fully/partially reversed.

#### **D - CORF**

- Number of CORF bills denied.

#### **E - Audits Days Visits/Charges**

- Number of HHA visits reviewed on MR audit;
- Outpatient hospital charges reviewed on MR audit; and
- Other provider charges reviewed on MR audit.

#### **F - SNF Audits**

- Number of SNF days reviewed on MR audit; and

- Number of SNF days denied on MR audit.

#### **G - Demand Bills Reviewed**

- Number of demand bills reviewed for SNFs, HHAs, and other; and
- Amount of savings claimed for HHA and other demand bills that the intermediary affirms.

#### **6.2.2 - Screen 7{tc \l3 "6.2.2 -- Screen 7}**

##### **A - PT**

- Number of PT bills reviewed;
- Amount of charges for PT bills reviewed;
- Number of PT bills denied; and
- Amount of charges denied for PT bills reviewed.

##### **B - OT**

- Number of OT bills reviewed;
- Amount of charges for OT bills reviewed;
- Number of OT bills denied; and
- Amount of charges denied for OT bills reviewed.

##### **C - Speech Therapy (ST)**

- Number of ST bills reviewed;
- Amount of charges for ST bills reviewed;
- Number of ST bills denied; and
- Amount of charges denied for ST bills reviewed denied.

#### **6.2.3 - Other Review Data{tc \l3 "6.2.3 -- Other Review Data}**

##### **A - MR of SNF Bills**

- Number of payment claims reviewed

- Number of payment claims denied
- URC/SNF continued stay denials reviewed
- URC/SNF continued stay partially/fully reversed
- Demand bills reviewed

**B – MR With Use of Therapy Screens**

	<b>PT</b>	<b>OT</b>	<b>ST</b>
Number of Bills Passing Screens			
Number of Bills Suspending Screens			
Charges on Bills Passing Screens			
Charges on Bills Suspended Screens			
Number of Bills Reviewed			
Number of Bills Denied			
Charges Denied			

**C - Other Therapy MR**

	<b>PT</b>		<b>OT</b>		<b>ST</b>	
	P/P Sample	Other	P/P Sample	Other	P/P Sample	Other
Number of claims reviewed						
Number of claims denied						

Charges reviewed

Charges denied

## **7 - FMR Activity Report {tc \11 '7 -- Focused Medical Review Activity Report }**

Intermediaries must complete the report semi-annually. (See Exhibit 2.) The reporting periods must cover the first two quarters of the FY (i.e., November thru April) and the last two quarters (i.e., May thru October) of the FY. Within 45 days of the end of the reporting periods, i.e., by May 15 for the first reporting period and by November 14 for the second reporting period, they submit one copy of the report to the RO and one copy to CO at the address below:

Health Care Financing Administration  
Program Integrity Group  
Mail Stop: C3-02-16  
7500 Security Boulevard  
Baltimore, MD 21244

Report the following elements:

- Date report was prepared;
- Contact name and telephone number;
- Period covered by the report;
- FMR criteria (specific revenue code, HCPCS code, provider, etc.) being reviewed;
- Reason for selection. Show the specific reason the FMR edit was selected (e.g., the providers rank in the top 5 percent in utilization of MRIs, referral from fraud unit, utilization aberrancy, or new technology);
- Date established (the date the edit was initially established);
- Actions taken. Intermediaries show the actions taken to resolve problems, e.g., educational efforts, fraud referrals, development of LMRP (attach copy); and
- Effectiveness. Intermediaries show the following:
  - Number of bills medically reviewed;
  - Percent of bills partially or fully denied;
  - Average or actual charges, days, or visits reviewed under criteria;
  - Average or actual charges, days, or visits denied;

- Percent of increase or decrease of days/visits/charges denied from previous period if edit has been in place during a prior period;
  - Approximate charges billed in prior period versus current period to show cost avoided as a result of provider practice change;
  - The cost benefit ratio (CBR) which is based on the average unit cost for review per bill type and savings as computed on the RBS. The CBR is required if you are using denials as the reason for continuing the edit;
  - Other measurable result or reason the edit is being continued. If an edit is discontinued or modified and one of the above results are not applicable, give the reason for discontinuation or modification; or
  - Estimated or potential overpayment for referrals to fraud.
- Reasons for denials. Intermediaries list reasons claims are denied under this edit; and
  - Status. Intermediaries show continued, discontinued, or modified status, as applicable. If the edit was modified prior to the reporting period, the FMR criteria described must reflect the modified edit. If the modification occurs during the reporting period, they identify the changes.

## **A - Summary Sheet**

Intermediaries must provide the following information on a cover sheet to the report:

- Number of edits reviewed this period;
- Number of edits modified or discontinued this period; and
- Number of edits reviewed in effect for 12 months or more.

They show the edit number on the report and indicate any actions taken by the intermediary or the providers as a result of the problem being identified.

**EXAMPLES:** Edits 1, 5, and 6 - conducted provider education meetings.

Edit 6 - provider changed billing practice.

Edit SNF 2 - generated provider bulletin, no change in billing practices to date.

When applicable, intermediaries include on the cover sheet any of the following information:

- New hardware or software development that the intermediary found particularly effective in conducting data analysis. Include any commercial products reviewed and believe would be of benefit;
- Any new patterns, trends, or problem identifications found to be significant. This includes any referrals to the fraud unit;
- Any new coverage issues that require clarification or development of national policy; and
- Any new FMR issues that need to be brought to the attention of other intermediaries, carriers, the PROs, ROs, and/or CO. Forward copies of all MR bulletins to CO on a regular basis.

## **8 -- Report of Benefit Savings (RBS){tc \l1 "8 -- Report of Benefit Savings (RBS)}**

Contractors transmit the RBS for each calendar quarter within 30 calendar days after the end of the reporting quarter. They may add, browse, update, or delete records at any time, and as many times as needed, until CO invokes the close out function at the end of each quarter. They will be notified by CO in the HCFA newsletter when this is to take place. Once the record has been closed they may only browse it. If for any reason a modification is needed to a closed record, they submit a facsimile of the transmitted report with the changes highlighted to:

Health Care Financing Administration  
 Program Integrity Group  
 Mail Stop: C3-02-16  
 7500 Security Boulevard  
 Baltimore, MD 21244

### **8.1 - Types of Savings to Report- Denials{tc \l2 "8.1 -- Types of Savings to Report- Denials}**

Intermediaries report all savings attributable to denials if the services were non-covered under §§1862(a)(1), (7), (8), (9), (10), (12) and (13) of the Act, or because they were not documented on the record as:

- Having been ordered by the physician or provided to the patient; or
- Were determined through MR not to meet other documentation or coverage requirements of the law, regulations or coverage policy issuances.

Intermediaries report savings resulting from MR in the following areas:

- Home health visits;
- Inpatient hospital and SNF ancillaries billed to Part B;
- Non-covered services furnished by a RHC, rehabilitation facility and/or CORF;

- Program integrity reviews performed and overpayments recovered;
- HHA compliance and post-payment reviews;
- Hospice services, i.e., charges for denied days/services and/or difference between charges for level of care billed and level of care determined to be reasonable and necessary;
- Inpatient SNF;
- Overpayments and savings from post-payment MR. The amount reported must be the direct result of MR and determined to be an overpayment;
- Outpatient hospital, HHA and SNF services;
- Laboratory, supplies, or drugs which exceed frequencies outside of the ESRD composite rate and are not medically necessary;
- Claims denied because a provider failed to comply with contractor request for documentation within prescribed time frames;
- Charges denied or deleted from the claim as a result of contractor identification of billing errors during the course of MR. For example, the contractor questions the medical necessity of a service and finds the service was billed in error; and
- Difference between charges for services billed and charges for services determined to be medically necessary e.g., reduction of air ambulance service charges to charges for land ambulance.

The services non-covered under §§1862(a)(1), and (7),(8),(9),(10),(12) and (13) of the Act are items and services that are not reasonable and medically necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

When reporting savings, intermediaries apply the following rules:

- Report savings resulting from medical review by:
  - Health professionals;
  - Clerical staff trained in medical and utilization review and using guidelines developed by health professionals; and
  - Electronic edits developed by health professionals and approved by the RO;
- Take credit for denials paid under waiver;

- Breakdown HHA savings by type of visit;
- Do not include savings resulting from bilateral joint reviews. It is a claims processing function to assure that bilateral joints are inserted during the stay;
- Do not report as savings electronic or automatic manual denials of excluded or non-covered services which do not require exercise of medical judgment (e.g., excluded ICD-9 codes; V70.0 routine general medical examination);
- Take credit for the actual number of days on a SNF demand bill if the reviewer concurs with a provider's non-covered determination based on review of the bill and medical information. For services prior to 1/1/89 and on and after 1/1/90, report the coinsurance amount beginning with the 21st day of each benefit period. For services 1/1/89-12/31/89 report coinsurance amount for the first 8 days; and
- For all other SNF bills, take credit for the number of days the reviewer determines to be non-covered. Report the actual coinsurance amount.

## 8.2 - Completion of the RBS

Intermediaries input data for the RBS through the personal computer or terminal via the HCFA data center. They input only the bold data elements. Computations are performed by the system. Five screens are provided to capture all data from the RBS.

Intermediaries enter the following information at the beginning of screen number 1.

**Contact Name** Enter the name of the individual responsible for completing the report.

**Contact Phone** Enter the area code and phone number of the individual responsible for the report.

The savings categories are on the screens in codes numbered 1 thru 32.

<u>CODE</u>	<u>CATEGORY</u>	<u>SAVINGS</u>
1	Hospital PPS	Charges for excluded or noncovered services billed by hospitals detected by PRO; services for hospice patients related to terminal illness.
2	Hospital Non-PPS	Same as PPS; Noncovered services in foreign hospitals.
3	Hospital Outpatient (OP)	Non-covered OP services billed by a hospital.

4	Hospital Ancillary-IP	Non-covered ancillary services billed by a hospital; includes Part B billing for an inpatient and ancillary review when a PRO denies a stay.
5	SNF Days	Inpatient SNF days determined to be non-covered.
6	SNF OP Charges	Non-covered OP services billed by a SNF.
7	SNF Ancillary Charges	Non-covered ancillary services billed under Part B for a SNF inpatient; Ancillary services denied on a Part A bill for SNF inpatient.
8	ESRD	Non-covered charges; Charges outside of composite rate which are medically unnecessary for hospital based and free standing facilities.
9	OP PT/Rehab	Non-covered services billed by rehab facilities (bill type 74) other than CORFs.
10	CORF	Self explanatory.
11	RHC	Self explanatory.
12	Other Part B	All Part B non-covered services not covered by an existing category.
13	Program Integrity Savings	Recoveries from PI and other audits conducted.
14	Open Biopsy	Number of reviews resulting in both a DRG assignment to closed biopsy and lower weighted DRG.
15	OP Hospital Audits	Recoveries from non-covered services identified on OP hospital audits.
16	Other Audits	Recoveries from non-covered services identified on all other audits.
17	SNF Demand Days	SNF days determined to be non-covered by provider, and the contractor concurs.

18-23	HHA Visits	Visits provided under a home health plan of care (HCFA-485) determined to be non-covered on prepayment review.
24	HHA DME/Supplies	Non-covered charges for DME/supplies under a home health plan of treatment detected on pre or post-payment review.
25	OP Home Health	Non-covered charges billed by HHAs under Part B, not under HCFA-485 plan of care.
26	Hospice	Difference in charges when inappropriate hospice level is billed and non-covered services.
27-32	CCR/HHA visits	HHA visits determined to be non-covered under post-payment review (i.e., coverage compliance or audit).

Intermediaries enter data in the four columns provided for each category on Screens 1-3. They round all charges to the nearest whole dollar. The four columns are:

- TOT DEN SER CHG FOR QTR;
- DEN PD UND WAV OF LIAB;
- DEN'REP ON RECON H&A; and
- APP-DED CO INSUR AMTS

<b>A Total Denied Services/Charges for Quarter</b>	Enter the total charges, visits, or days denied under MR in the reporting quarter.
<b>B Denials Paid Under Waiver of Liability</b>	Enter the charges/days/visits paid under waiver of liability. If you previously reported a claim as denied not paid under waiver, and it is subsequently paid under waiver, report the information in this column only. Exclude denials paid under waiver which were overturned in the current quarter (i.e., included in Item D).
<b>C Charges Net of Waiver</b>	The difference between Items A and B. Computations are performed by the system.
<b>D Denied and Reported Charges, Days, or Visits Overturned on Informal Re-Review, Reconsideration, Hearing or</b>	Enter previously denied charges, days or visits for denials which were overturned (i.e., paid as covered services) upon appeals. Enter these charges, days or visits <b>only</b> if they:

**Appeal**

\$ Were denied (including denied charges, days, visits paid under waiver);

\$ Were reported as savings in a previous report; or

\$ Are reported as savings for the current quarter in Item A

**E Net Denied Charges, Days, or Visits**

The difference between Items C and D. Computations are performed by the system.

**F Conversion Factors**

HCFA converts days, charges, and visits to costs on the RBS. The updated factors apply to the reported savings shown on the RBS effective for the quarter beginning 10/95. The factors are entered by the system.

**G Factored Amount**

The product of net denied charges, days or visits times the conversion factor. This is the factored amount from which Item H (the applicable deductible and coinsurance amounts) are deducted. Computations are performed by the system.

**H Applicable Deductible and Coinsurance Amount**

Enter the applicable deductible and coinsurance amounts for Part A and Part B. If the contractor adjusts the deductible amounts later (e.g., as a result of an adjustment), do not adjust the previously reported savings. Show an amount in this field for all Part B services that are subject to the 20% coinsurance (i.e., categories 3,4,6,7-12, and 25). Show the sum of applicable deductibles and the 20% coinsurance amounts. The deductible and coinsurance amounts are the amounts that would be applicable (i.e., amounts the program would not pay) if the claim were paid in full. It does not matter whether the beneficiary is held liable for payment for the amounts. If the system does not retain actual coinsurance amounts, compute the 20% by subtracting the deductible amounts from net denied charges on line (E) and multiplying the remainder by 20%. Show coinsurance amounts that would have been applicable to SNF days and SNF demand bill days. If the actual coinsurance amount for each SNF bill cannot be determined, estimate it by applying the current year coinsurance rate to half of

the SNF days reported. Enter this amount in category H. Coinsurance should be zero if there is a negative amount in column E.

**EXAMPLE:** The denied days reported in column A = 100. The coinsurance rate is \$97.00 per day. Multiply 50 (2 of denied days) by \$97.00 = \$4850 estimated coinsurance.

**I Total Saved**

This represents the total benefit savings after all computations. Computations are performed by the system.

**J Total Saved Including Waiver Denials**

This represents the total benefit savings including waiver. Computations are performed by the system.

For MR cost and number of bills reviewed, intermediaries enter data in the two items provided for each category as follows.

- A **Number of Bills Reviewed** Enter the total number of bills reviewed by bill type.
- B **MR Cost** Enter the MR cost by review type. The total MR cost should approximate Interim Expenditure Report (IER) costs for the quarter. However, there may be special implementation or other costs that can be excluded. The RO will advise you of costs to exclude. Do not enter cumulative costs.
- C **Totals** Enter total number of bills reviewed and costs in the space provided.

For the number of bills reviewed, audits, and MR cost, intermediaries enter data in the following 4 items provided for each category.

- A **Number of Bills Reviewed** Enter the number of bills reviewed.
- B **Number of Providers Audited** Enter the number of providers audited on-site and in-house.
- C **MR Cost** Enter cost of on-site and in-house audits.
- D **Totals** Enter total number of bills reviewed, providers audits, and costs in the space provided.

### **9 B Retain Data to Support Savings Reported on the RBS**

Intermediaries retain documentation to support the savings reported on the RBS for validation. At a minimum, documentation must include:

- A record, by quarter reported, of each denied claim with the following data:
  - Sufficient identification to retrieve the claim and medical documentation (if applicable);
  - Amount of denied or deleted charges and/or number of denied days/visits;
  - Deductible amount applicable to claim or which would have applied if claim was paid;
  - Coinsurance amount applicable to denied days/charges or which would have applied if days/charges were paid (unnecessary if coinsurance is computed as in PIM Chapter 7 §8.2 subsection H above.);

- Charges/days paid under waiver; and
  - Reviewer's ID or automatic denial indication.
- A record, by quarter, of reported days/visits and charges reversed on reconsideration/hearings and appeals.

An auditor or reviewer validating reported savings must be able to review contractor documentation and the claim to verify the entries on the report that the denial was made by the level of staff (or system) required for medical review, and that sufficient medical documentation (e.g., on the claim) was available to make the determination.

**10 – List of MR Codes, Categories, and Conversion Factors for FY 2000**{tc "11 – List of MR Codes, Categories, and Conversion Factors for FY 2000"}

<u>Code</u>	<u>Category</u>	<u>Conversion Factor</u>
1	Hospital PPS	100%
2	Hospital Non-PPS	78.63%
3	Hospital Outpatient	78.72%
4	Hospital Ancillary Charge	62.91%
5	SNF Days Non PPS	\$227.00
6	SNF Outpatient Charges	72%
7	SNF Ancillary Charges	80%
8	ESRD	80%
9	Outpatient PT/Rehab	80%
10	CORF	80%
11	Rural Health Center	80%
12	Other Part B	80%
13	Program Integrity Savings	100%
14	Open biopsy	\$3,000 per review
15	All Audits	100%
16	SNF PPS & SNF PPS Demand Days	\$233.72
17	SNF Non PPS Demand Days	\$227.00
18	HHA S.N. Visit	\$102.57
19	HHA S.T. Visit	\$119.90
20	HHA P.T. Visit	\$117.54
21	HHA Aide Visit	\$46.39
22	HHA O.T. Visit	\$118.92
23	HHA M.S.S. Visit	\$147.52

24	HHA DME/Supplies	80%
25	Outpatient HHA (PartB)	80%
26	Hospice	80%
27	CCR S.N. Visit	\$102.57
28	CCR S.T. Visit	\$119.90
29	CCR P.T. Visit	\$117.54
30	CCR Aide Visit	\$46.39
31	CCR O.T. Visit	\$118.92
32	CCR M.S.S. Visit	\$147.52

Use conversion factors to convert charges to costs.

# Medicare Program Integrity Manual

## Chapter 8 B Program Memorandums

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#### **1 B Intermediary Program Memoranda**

#### **2 B Carrier Program Memoranda**

B B 98-6 Durable Medical Equipment Regional Carrier (DMERC) Instructions for Denying Claims and Recovering Overpayments for Prescription Drugs Billed and/or Paid to Suppliers Not Licensed to Dispense Prescription Drugs B {tc \l2 "B B 98-6 Durable Medical Equipment Regional Carrier (DMERC) Instructions for Denying Claims and Recovering Overpayments for Prescription Drugs Billed and/or Paid to Suppliers Not Licensed to Dispense Prescription Drugs B }February 1998

B B 98-43 Changes in the Medicare Limiting Charge Monitoring Program for Fiscal Year (FY) 1999{tc \l2 "B B 98-43 Changes in the Medicare Limiting Charge Monitoring Program for Fiscal Year (FY) 1999} B November, 1998

B B 98-44 Evaluating the Medical Necessity for Laboratory Panel CPT Codes{tc \l2 "B B 98-44 Evaluating the Medical Necessity for Laboratory Panel CPT Codes} B November, 1999

B B 99-1 Evaluating the Medical Necessity for Laboratory Panel CPT Codes{tc \l2 "B B 99-1 Evaluating the Medical Necessity for Laboratory Panel CPT Codes} B January, 1999

B B 99-3 Revisions to Transmittal No. AB-98-14 Dated April 1998 "Claims Processing Instructions for the National Institutes of Health National Emphysema Treatment Trial (NETT)"{tc \l2 "B B 99-3 Revisions to Transmittal No. AB-98-14 Dated April 1998 "Claims Processing Instructions for the National Institutes of Health National Emphysema Treatment Trial (NETT)"} B February, 1999.

#### **3 B Intermediary/Carrier Program Memoranda**

AB-98- 4 Implementation of the Office of the Inspector's General (OIG) Fraud Hot Line Number on Medicare Beneficiary Notices{tc \l2 "AB-98- 4 Implementation of the Office of the Inspector's General (OIG) Fraud Hot Line Number on Medicare Beneficiary Notices} B February 1998

AB-98-52 Interim Tracking Procedures for Implementing the Medicare Fraud and Abuse Incentive Reward program (IRP {tc \l2 "AB-98-52 Interim Tracking Procedures for

Implementing the Medicare Fraud and Abuse Incentive Reward program (IRP) } B Action This Program Memorandum instruction was superseded by Program Memorandum 99-5 which can be found in Chapter 2, §3.6.

AB-98-77 Referral of Cases to the Office of Inspector General (OIG){tc \l2 "AB-98-77 Referral of Cases to the Office of Inspector General (OIG)} This Program Memorandum instruction can be found in Chapter 3, §10.

AB-99 B 5 Instructions for Implementing and Tracking the Medicare Fraud and Abuse Incentive Reward Program (IRP) B {tc \l2 "AB-99 B 5 Instructions for Implementing and Tracking the Medicare Fraud and Abuse Incentive Reward Program (IRP) B }ACTION This Program Memorandum instruction can be found in Chapter 2, §3.6.

## Medicare Program Integrity Manual

### Chapter 9 – MR Information Reported Electronically

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## **1 – MR Information Reported Electronically {tc "1 -- Medical Review Information Reported Electronically "}**

This section describes MR information that may be submitted electronically to the intermediary.

## **2 - Electronic Medical Record For Outpatient Rehabilitation Services: Record Type (RT) 77{tc "2 -- Electronic Medical Record For Outpatient Rehabilitation Services: Record Type (RT) 77"}**

RT 77 allows providers to submit outpatient rehabilitative services information within the current UB-92 flat file structure. It includes information submitted on Forms HCFA-700 (Plan of Treatment for Outpatient Rehabilitation) and HCFA-701 (Updated Plan of Progress for Outpatient Rehabilitation). RT 77 is a series of records that can be submitted with the claim, or can be sent in a transaction separate from the claim. All sequences and filler fields of RT 77 are reserved for national use. Although this record series was designed for use by the Medicare program, it may be used by other payers, but they must utilize the UB-92 field definitions and requirements. Pass this information to all payers that have a coordination of benefits (COB) agreement with Medicare.

Providers send information independent of the claim only upon request by the intermediary for MR purposes. A provider may send RT 77 with other medical record data (e.g., RT 75 for ambulance) in one transaction. However, the provider must follow all restrictions established for these records, including the submission of RT 74 (Patient Information Record) with these records when submitting them independent of the claim. Each RT 74 indicates the claim for which the medical records are provided.

No proprietary or local electronic attachment for outpatient rehabilitative services is accepted.

### **A - Submission With Claim**

If the provider submits the information with the claim, RT 20 provides patient information. Record types 01, 10, 20, 30, 40, 61, and 70 precede the submission of RT 77. Record types 80, 90, 95, and 99 follow the submission of the series of attachment records.

### **B - Submission Independent of Claim**

Providers must notify the intermediary prior to their initial submission of electronic medical records independent of the claim. The contractor will determine what testing is needed. When submitting medical records independent of the claim, the provider must send a batch containing only medical records. Providers may not mix claims in a medical records batch. This batch may contain multiple attachments for multiple claims. However, each new claim must be indicated by a new RT 74. A file submission can contain batches of claims and batches of medical record.

If the intermediary requests additional information regarding a claim, the provider must submit RT 74 for each unique claim for which additional information is requested. Field 21 (Internal Control/Document Control Number (ICN/DCN) in RT 74 is used to match medical information submitted independent of the claim to the claim awaiting information. It can also match the medical record to a paid claim in history files. The intermediary will provide the ICN/DCN of the suspended claim to the provider with the request for information. The provider must return

this information to the intermediary. The intermediary may reject a medical record if an ICN/DCN is not entered.

### **C - Use of RT 77**

The intermediary must edit the medical record and retain the records for use by the appropriate MR personnel.

Follow all current HCFA MR guidelines and requirements to review the claim. Retain information submitted on RT 77 as part of the audit trail according to current HCFA instructions. The MR staff must use RT 77 as they currently use paper forms, such as Forms HCFA-700/701, to collect information regarding outpatient rehabilitative services. RT 77 series allows the intermediary to receive from the provider the types of narrative assessments and descriptions required for MR. MR should limit the requested narrative information to only what is necessary for review.

### **D - Record Layouts**

Record layouts, data element definitions, descriptions and sequencing rules can be found on the HCFA EDI Home Page on the Internet. All filler is for national use only. The web address is: <http://www.HCFA.gov/medicare/edi/edi3>

### **E - Example of the Sequence for Medical Information**

The records in RT 77 series must be created in sequential order beginning with one and increasing by increments of one. When submitting information for multiple disciplines, all records for a single discipline (e.g., PT) must be created before beginning records for a subsequent discipline (e.g., OT). RT 77, format A signals the beginning of information for a specific discipline and is always followed by format R. Depending upon the intermediary requests and requirements for documentation, format N records may follow.

There are eight available narrative types depending upon the intermediary's requests and requirements for medical documentation. For any one discipline (e.g., PT), each narrative type, **except type 05 (progress report)**, can be submitted zero to three times, based on the volume of information and intermediary guidelines. Narrative type 05 (progress report) can be submitted zero to **six** (6) times. All sequences for a specific narrative type for a discipline must be created before beginning a new narrative type. An example of proper sequencing follows.

In the example, the intermediary requested information regarding a specific claim that included billing for PT, OT, and ST. The intermediary also requested information regarding occupational therapy on a second claim and ambulance services on a third claim. In the example, RT 74 is used since information is being sent independent of the claim. If the medical attachments were being sent with the claim, RT 74 would not be used, and a new claim would begin with RT 20.

The provider is submitting the following information for each discipline based upon the original claim (a plan of treatment is created for each discipline):

Claim one:

- I. PT - Medical history, prior level of function, progress report and justification for continued treatment;

- II. OT - Initial assessment and progress report; and,
- III. ST - Medical history, prior level of function, functional goals, progress report, and justification for continued treatment.

Claim two:

**{tc "Claim two: "}**

- OT - Medical history, assessment, and progress report.

<u>RT</u>	<u>Record Name</u>	<u>Seq</u>	<u>Format</u>	<u>Disc</u>	<u>Narrative Type</u>
10	Provider Data				
74	Patient Information				
77	Rehab. Admin Data	01	A		PT
77	Rehab. Treatment 02	R		PT	
77	Rehab. Treatment 03	N		PT	01 (Hist/PLF)
77	Rehab. Treatment 04	N		PT	01 (Hist/PLF)
77	Rehab. Treatment 05	N		PT	05 (Progress)
77	Rehab. Treatment 06	N		PT	05 (Progress)
77	Rehab. Treatment 07	N		PT	05 (Progress)
77	Rehab. Treatment 08	N		PT	06 (Continue)
77	Rehab. Admin Data	09	A		OT
77	Rehab. Treatment 10	R		OT	
77	Rehab. Narrative 11	N		OT	02 (Assessment)
77	Rehab. Narrative 12	N		OT	05 (Progress)
77	Rehab.-Admin Data	13	A		ST
77	Rehab. Treatment	14	R	ST	
77	Rehab Narrative	15	N	ST	01(Hist/PLF)
77	Rehab. Narrative	16	N	ST	03 (Goals)
77	Rehab. Narrative	17	N	ST	03 (Goals)
77	Rehab. Narrative	18	N	ST	05 (Progress)
77	Rehab. Narrative	19	N	ST	06 (Continue)
77	Rehab. Narrative	20	N	ST	06 (Continue)
90	Claim Control Screen				
74	Patient Information				
77	Rehab. Admin Data	01	A		OT
77	Rehab. Treatment 02	R		OT	
77	Rehab.-Narrative 03	N		OT	01 (Hist/PLF)

77	Rehab.-Narrative 04	N	OT	02 (Assessment)
77	Rehab.-Narrative 05	N	OT	02 (Assessment)
77	Rehab.-Narrative 06	N	OT	05 (Progress)
90	Claim Control Screen			
74	Patient Information			
75	Ambulance	01		
75	Ambulance	02		
90	Claim Control Screen			
95	Provider Batch Control			

**2.1 - Crosswalk of RT 74 (Patient Information) and HCFA Forms 700 and 701 {tc "2.1 -- Crosswalk of Record Type 74 (Patient Information) and HCFA Forms 700 and 701" \1 2}**

The crosswalk includes the RT 74 field number and name, and the paper form HCFA 700/701 field number. The following field requirements for RT 74 are for use only when submitting outpatient rehabilitative service information. Valid code values are in column three.

<u>Flat File Field</u>	<u>Data Element</u>	<u>Code Validation</u>	<u>HCFA 700/701 Form Box</u>
1	Record Type	74	None
2	Filler		None
3	Patient Control Number	Specified by provider	
4	Attachment Submission Code	A(space)-Add,U(space)-Update	None
5	HICN	Valid Medicare HIC number	700-3, 701-3
6	Medical Record Number	Specified by provider	700-5, 701-5
7	Patient Last Name	Narrative text	700-1, 701-1
8	Patient First Name	Narrative text	700-1, 701-1
9	Patient Name Middle Initial	Narrative text	700-1, 701-1
10	Patient Birthdate	Date must be CCYYMMDD	
11	Patient Sex	M-Male, F-Female, U-Unknown	
12	Principal Diagnosis Code	Valid ICD-9-CM code	700-9, 701-9
13	Other Diagnosis Code-1	Valid ICD-9-CM code	700-10, 701-10
14	Other Diagnosis Code-2	Valid ICD-9-CM code	700-10, 701-10
15	Other Diagnosis Code-3	Valid ICD-9-CM code	700-10, 701-10
16	Other Diagnosis Code-4	Valid ICD-9-CM code	700-10, 701-10

17	Start of Care/Admission Date	Date must be CCYYMMDD	700-7, 701-7
18	Statement Covers Period From Date	Date must be CCYYMMDD	700-22, 701-23
19	Statement Cover Period Through Date	Date must be CCYYMMDD	700-22, 701-23
20	Provider Number	Valid HCFA provider number (for institution)	700-4, 701-4
21	Internal Control or Document Control Number (ICN/DCN)	Number assigned by internal claims processing system to original claim RT 74 is to be associated to	
22	Filler	N/A	

If providers are submitting multiple disciplines for a unique claim, indicated by RT 74, the start of care date for the first discipline should be entered in field 17. While this may seem redundant, it promotes consistency in the use of RT 74 with other attachments (e.g., RT 71 for home health care). The start of care date is indicated for each discipline in RT 77, format A, field 24.

## 2.2 - Crosswalk of RT 77 Format A (Administrative Data) and HCFA Forms 700 and 701

This record should be submitted for each discipline. There is one and only one format A for each discipline. It must be followed by RT 77, format R.

<u>Flat File Field</u>	<u>Data Element</u>	<u>Code Validation</u>	<u>HCFA 700/701 Form Box</u>
1	Record Type	77	
2	Sequence Number	01-99	
3	Patient Control Number	Specified by provider	
4	Record Format	A-Administrative Data	
5	Discipline	SN-Skilled Nursing, PT-Physical Therapy, ST-Speech Language Pathology, OT-Occupational Therapy MS-Social Work, CR-Cardiac Rehabilitation RT-Respiratory (Inhalation)Therapy PS-Psychiatric Services	700-8, 701-8
6	Attending Physician Number (UPIN)	Valid HCFA UPIN	700-15, 701-15
7	Physician Referral Date	Date must be CCYYMMDD	
8	Physician Signature Date on Plan of Treatment	Date must be CCYYMMDD	700-16, 701-16
9	Rehabilitation Professional	Valid HCFA UPIN	700-13, 701-19

	Identifier (UPIN)		
10	Rehabilitation Professional Name (Last)	Narrative text	
11	Rehabilitation Professional Name (First)	Narrative text	700-13, 701-19
12	Rehabilitation Professional Name (Middle Initial)	Narrative text	700-13, 701-19
13	Professional Designation of Rehabilitation Professional	Narrative text	700-13, 701-19
14	Rehabilitation Professional Signature Date on Plan of Treatment	Date must be CCYYMMDD	701-20
15	Prior Hospitalization Date - From Date	Date must be CCYYMMDD	700-19
16	Prior Hospitalization Date - Through Date	Date must be CCYYMMDD	700-19
17	Date of Onset Exacerbation of Principal Diagnosis	Date must be CCYYMMDD. 01 will be day if exact date is unknown.	700-6, 701-6
18	Admission Date Start of Care Date	Date must be CCYYMMDD.	700-7, 701-7
19	Total Visits From Start of Care		700-11, 701-11
20	Date of Most Recent Event Requiring Cardiac Rehabilitation	Date must be CCYYMMDD	
21	Treatment Diagnosis Code (ICD-9)	Valid ICD-9-CM code	700-10, 701-10
22	Treatment Diagnosis (Narrative)	Narrative text	700-10, 701-10
23	Filler		

**2.3 - Crosswalk of RT 77 Format R (Treatment Data) and HCFA Forms 700 and 701{tc "2.3 -- Crosswalk of Record Type 77 Format R (Treatment Data) and HCFA Forms 700 and 701" \l 2}**

This record is for information related to the rehabilitative services plan of treatment. It must follow RT 77, format A. There is one and only one format R for each discipline submitted.

Flat	<u>Data Element</u>	<u>Code Validation</u>	HCFA 700/701
------	---------------------	------------------------	--------------

<u>File Field</u>			<u>Form Box</u>
1	Record Type	77	
2	Sequence Number	01-99	
3	Patient Control Number	Specified by provider	
4	Record Format	R-Treatment Data	
5	Discipline XX	SN-Skilled Nursing, PT-Physical Therapy, ST-Speech Language Pathology, OT-Occupational Therapy, MS-Social Work, CR-Cardiac Rehabilitation, RT-Respiratory (Inhalation) Therapy, PS-Psychiatric Services	700-8, 701-8
6	Plan of Treatment Status (Initial/Update)	700-Original plan of treatment 701-Updated plan of treatment	
7	Plan of Treatment Date Established	Date must be CCYYMMDD	
8	Plan of Treatment Period Covered - From Date	Date must be CCYYMMDD	
9	Plan of Treatment - Period Covered - Through Date	Date must be CCYYMMDD	
10	Frequency/Duration	See Below	700-14, 701-12
	Frequency	1 through 9	700-14, 701-12
	Frequency Period	DA-Day, WK-Week, MO-Month, Q(space)-every n days where n = days in duration (2 spaces)-PRN (whenever necessary)	700-14, 701-12
	Duration (in days)	001-999 PRN-only if 2 spaces are in frequency period	700-14, 701-12
11	Estimated Date of Completion	Date must be MMDDYY	
12	Service Status (Continue/Discontinue)	1-Continue, 2-Discontinue	700-21, 701-21
13	Certification Status	01-Certification, 02-Re-certification, 99-Not Applicable	
14	Date of Last Certification	Date must be CCYYMMDD	
15	Route of Administration -IM	Y-If present, equals yes N-If present, equals no	

16	Route of Administration -IV	Y-If present, equals yes N-If present, equals no
17	Route of Administration -PO	Y-If present, equals yes N-If present, equals no
18	Drugs Administration (Narrative)	Narrative Text
19	Prognosis Potential	1-Poor, 2-Guarded, 3-Fair, 4-Good 5-Excellent
20	Filler	

**2.4 - Crosswalk of RT 77 Format N (Narrative Text) and HCFA Forms 700 and 701 {tc "2.4 -- Crosswalk of Record Type 77 Format N (Narrative Text) and HCFA Forms 700 and 701 " \1 2}**

This record supports narrative text for assessment and descriptive narrative from the plan of treatment. Intermediaries must inform providers of the narrative needed to adequately perform MR. Multiple sequences of specific narrative types may be repeated to accommodate text information. Narrative for a specific type (e.g., 01) can repeat up to but no more than three (3) times for a total of 456 bytes of information except narrative type 05 (progress report) which can repeat up to but no more than six times for a total of 912 bytes of information.

Create all records related to a specific narrative type sequentially before proceeding to a new narrative type. Narrative types must be in order (e.g., finish all of type 01 before proceeding to type 02 or 03). All narrative types related to a specific discipline (e.g., PT) must be completed before creating any records for a second or subsequent discipline (e.g., OT).

<u>Flat File Field</u>	<u>Data Element</u>	<u>Code Validation</u>	<u>HCFA 700/701 Form Box</u>
1	Record Type	77	
2	Sequence Number	01-99	
3	Patient control Number	Specified by Provider	
4	Record Format	N-Narrative text	
5	Discipline	SN-Skilled Nursing, PT-Physical Therapy, ST-Speech Language Pathology, OT-Occupational Therapy MS-Social Work CR-Cardiac Rehabilitation, RT-Respiratory (Inhalation) Therapy, PS-Psychiatric Services	700-8, 701-8

6	Narrative Type Indicator	01-Medical History, 02-Initial Assessment, 03-Functional Goals, 04-Plan of Treatment, 05-Progress Report, 06-Continued Treatment, 07-Justification for Admission, 08-Symptoms/Present Behavior	700-12, 20, 21 701-13, 18, 22
7	Free Form Narrative Text	Narrative Text	700-12, 20, 21 701-13, 18, 22
8	Filler		

### 2.4.1 - Definition of Narrative Type Indicators {tc "2.4.1 -- Definition of Narrative Type Indicators" \l 3}

Providers use narrative type indicators in RT 77, format N to describe the type of free form text submitted. This allows the intermediary to request or specify the type of information necessary for MR, and it allows the provider to indicate to the intermediary the topic being addressed.

Encourage providers to use ICD-9-CM and CPT codes in narrative text where appropriate to describe the patient's condition, goals, or progress. Encourage providers to submit information as concisely as possible while supporting MR documentation requirements.

<u>Indicator</u>	<u>Definition</u>
01	<b>Medical History/Prior Level of Function:</b> This describes pertinent medical information relative to services rendered. It benchmarks the functioning of the patient prior to the episode or event precipitating the need for services. Include only current, relevant history from the medical record or patient interview.
02	<b>Initial Assessment:</b> This describes the patient's functional level at the beginning of service and indicates the reason for referral. Provider also indicates any medical complications to the rehabilitative service that could influence the rehabilitation period. Include only baseline tests and measurements from which to judge future progress or lack thereof.
03	<b>Functional Goals:</b> This describes both short and long term goals (outcomes). Describe short term goals in terms of reaching overall long-term outcome(s).
04	<b>Plan of Treatment:</b> This briefly describes the major treatment plan to achieve functional goals. Estimate time frames, if possible. Specify modalities, procedures, or equipment to be used, where appropriate.

- 05                    **Progress Report:** This describes the patient's functional level at the end of the billing period in comparison to levels since last assessment. Encourage use of objective terminology and comparative data. Date progress when function can consistently be performed. When only a few visits have been made, indicate the training/treatment rendered and the patient's response. **NOTE:** Type 05 is the only narrative type that can be repeated up to six (6) times.
- 06                    **Continued Treatment:** This briefly states the patient's need for specific functional improvement and skilled training. This is/are the major reason(s) for continued skilled services in this billing period.
- 07                    **Justification for Admission:** This identifies precipitating events and behaviors necessitating psychiatric services.
- 08                    **Symptoms/Present Behavior:** This identifies symptoms and behavior being displayed during the treatment period (identified by the service dates on the claim) for psychiatric services.

**2.5 - Validating Information for Outpatient Rehabilitation Plan of Treatment Submissions {tc "2.5 -- Validating Information for Outpatient Rehabilitation Plan of Treatment Submissions" \1 2}**

Use code validations described above as a basis for establishing edits at the interface. The edits described here are required standard system edits and should be considered a minimum standard for validation. Others may be added. Intermediaries cannot change edits that already identify and validate this information. For example, the UPIN structure may be validated at the interface and verified as a provider once in the system, or the field may be verified at the interface for the presence of alphanumeric characters.

The ICN/DCN is the key for associating batch medical review attachments to the original claim with the same service dates and HIC number. If the ICN/DCN is not present, reject medical review batch attachments utilizing current procedures. If the provider does not submit valid information (e.g., UPIN is not valid, dates are not in acceptable structure), return the attachment records using current procedures for returning and correcting claims.

**2.5.1 - Conditional Edits for Submitting Rehabilitative Services Information Independent of Claim Data (USES RT 74).{tc "2.5.1 -- Conditional Edits for Submitting Rehabilitative Services Information Independent of Claim Data (USES RT 74)." \1 3}**

<u>Field</u>	<u>Edit</u>
Field 20 (Provider Number)	The value must match the value on the provider batch header record for this transmission (RT 10, field 6).

Field 21 (ICN/DCN)

This field is required because providers are submitting information independent of the claim data set. It matches the attachment records submitted to the original claim. Intermediaries reject batch attachments that do not contain an ICN/DCN.

## **2.5.2 - Conditional Edits Rehabilitative Services RT 77{tc "2.5.2 -- Conditional Edits Rehabilitative Services Record Types (RT) 77" \I 3}**

The edits described below apply to MR attachments sent with the claim data set and independent of the claim data set.

<u>Field</u>	<u>Edit</u>
Field 5 (Discipline)	The value for field 5 must be identical to field 5 on all records related to one discipline. All sequential records must contain the same value in field 5 until all information related to that discipline (including narrative records) is complete. A new record format A in a sequence must contain a new discipline. This field can be used as a matching criteria for sequential records. If the value for this field is PT, OT, or ST, then the value for Certification Status (RT 77, format R, field 13) must be 01 or 02.

### **A - Conditional Edits for RT 77, Format A (Administrative Data Record)**

<u>Field</u>	<u>Edit</u>
Field 9 Rehabilitation Professional Identifier (UPIN)	If this field is spaces (blank), then Rehabilitation Professional Name - Last (RT 77, format A, field 10) and Rehabilitation Professional Name - First (RT 77, format A, field 11) are required, and Rehabilitation Professional Name - Middle Initial (RT 77, format A, field 12) is optional.
Field 20 (Date of Most Recent Event Requiring Cardiac Rehabilitation)	If the value in RT 77, format A, field 5 (Discipline) is CR, this field is required.
Field 21 (Treatment Diagnosis Code)	If this field is a space (blank), then RT 77, format A, field 22 (Treatment Diagnosis Narrative) is required.

Field 22 (Treatment Diagnosis Narrative) If RT 77, format A, field 21 is space filled, then this field must contain narrative text diagnosis.

### **B – Conditional Edits for RT 77, Format R (Treatment Data Record)**

Field	Edit
Field 6 (Plan of Treatment Status (Initial/Update))	If the value for this field is 700, then the value for RT 77, format R, field 13 (Certification Status) must be 01 or 99. If the value for this field is 701, then the value for RT 77, format R, field 13 (Certification Status) must be 02 or 99.
Field 13 (Certification Status)	If the value in this field is 02, then RT 77, format R, field 14 (Date of Last Certification) is required. If the value in RT 77, format R, field 5 (Discipline) is PT, OT, or ST, only values of 01 and 02 are valid. If the value in RT 77, format R, field 6 (Status (Initial/Update)) is 700, then the value in this field must be 01 or 99. If the value in RT 77, format R, field 6 (Status (Initial/Update)) is 701, then the value in this field must be 02 or 99.
Field 14 (Date of Last Certification)	If the value in RT 77, format R, field 13 (Certification Status) is 02, this field must contain a valid date.

### **3 - EMC Flat File Record For ESRD Medical Documentation: Record Type (RT) 76**{tc "3. - EMC Flat File Record For ESRD Medical Documentation: Record Type (RT) 76"}

RT 76 allows providers to submit ESRD medical documentation information within the current UB-92 flat file structure. RT 76 was designed to facilitate the electronic submission of data used for the MR of ESRD related claims.

RT 76 is a pair of records that may be submitted with the claim, or it may be sent in a transaction separate from the claim. All sequences and filler fields of RT 76 are reserved for national use. Other payers may use RT 76 for ESRD information, but they must utilize the field definitions and requirements described by Medicare. Pass through this information to all payers that have signed a coordination of benefits (COB) agreements with the intermediary.

Providers send information independent of the claim only upon request by the intermediary for MR purposes. A provider may send RT 76 with other medical record data (e.g., RT 75 for ambulance) in one transaction. However, the provider must follow all restrictions established for these records, including the submission of RT 74 (Patient Information Record) with these records

when submitting them independent of the claim. Each RT 74 indicates the claim for which the medical records are provided.

No proprietary or local electronic attachment for outpatient rehabilitative services is accepted.

### **A - Submission With a Claim or Independent of a Claim**

The same submission rules applicable to RT 77 apply to RT 76. See § 7.1.5 above for submission rules. Narrative descriptions necessary to accompany information in RT 76 should be submitted in RT 90 and 91. MR should limit the requested narrative information to only what is necessary for review.

### **B - Use of RT 76**

Once the submitted records enter the claims processing system and pass all consistency edits, retain them for access by the appropriate MR personnel. Follow all current HCFA MR guidelines and requirements to review the claim. Retain information submitted on RT 76 as part of the audit trail according to current HCFA instructions.

### **C - Record Layouts**

Record layouts for RT 76, formats L and M, are located on the HCFA EDI Home Page on the internet. Individual data elements are also defined alphabetically. The address is:

<http://www.hcfa.gov/medicare/edi/edi3>

Only fields 1 through 4 on both formats L and M are required. Since there is no national policy on a data set for medical review of ESRD claims, all other fields are optional for provider and intermediary use in accordance with the intermediary MR policy.

All filler is for national use only. Filler fields following date fields are reserved for the capability of adding century dates.

### **D - Sequencing**

The records in RT 76 series must be created in sequential order beginning with one and increasing by increments of one.

RT 76, format L, signals the beginning of information for an ESRD claim. Multiple sequences of format L may be created to accommodate all necessary additional information. Depending upon the request, no format L may be submitted. If both format L and format M are necessary, RT 76, format M records follow format L records. Multiple sequences of format M may be created to accommodate all necessary additional information. A sequencing example follows.

<u>Record Type</u>	<u>Record Name</u>	<u>Seq</u>	<u>Format</u>
10	Provider Data		
74	Patient Information		

76	ESRD-Lab	01	L
76	ESRD - Lab	02	L
76	ESRD - Medication	03	M
76	ESRD - Medication	04	M
76	ESRD - Medication	05	M
74	Patient Information		
76	ESRD Medication	01	M
76	ESRD Medication	02	M
74	Patient Information	01	
76	ESRD-Lab	01	L
76	ESRD-Lab	02	L
76	ESRD-Lab	3	L
90	Claim Control Screen		

PIM Chapter 6 §14 addresses CWF alerts and contractor resolution responsibilities.

#### **4 - Argus Field Descriptions and Formats{tc "4 – Argus Field Descriptions and Formats"}**

##### STRUCTURE OF ARGUS.DBF

All Character fields are to be LEFT JUSTIFIED.  
 Leading Zeroes and Blanks are to be OMITTED.  
 All Numeric fields are to be RIGHT JUSTIFIED.  
 All dates must be in the form YYMMDD.

Field #	Name	HUBC Field #	HUBC Name	Type	Length	Description
1	Carrier	7	Processing Carrier	Character	5	ID of Carrier who processed claim
2	HICN	3	CLAIM NUMBER	Character	12	Claim Number
3	SURN AME	4A	BEN NAME-SURNAME	Character	6	First six positions of Beneficiary's last name
4	F_INIT IA	4B	BEN NAME-FIRST INITIAL	Character	1	First initial of Beneficiary's first name
5	DCN	23	DOCUMENT CONTROL	Character	5	Carrier assigned claim control

			NUM			number
6	PAID_ DT	26	DATE CLAIM PAID/DENIED	Numeric	6	Date claim paid/Denied
7	RENDERIN	79	PROVIDER NUMBER	Character	10	Carrier assigned ID number for the physician performing services
8	REFERRIN	24	REFERRING PHYSICIAN	Character	14	Carrier assigned ID number for the referring, prescribing or ordering physician
9	TYPE_ SER	59	TYPE OF SERVICE	Character	1	Represents the type of service as specified by HCFA 0-Whole Blood or Packed Red Cells 1-Medical Care 2-Surgery 3-Consultation 4-Diagnostic X- Ray 5-Diagnostic Laboratory 6-Radiation Therapy 7-Anesthesia 8-Assistance at Surgery 9-Other Medical Service A-Used DME B-High risk Mammography C-Low risk Mammography F-Ambulatory surgical Center (Facility Usage) G- Immunosuppressiv e drugs received within 12 months of a Medicare

covered transplant  
 I-Install purchase  
 DME  
 L –Renal supplier  
 in home  
 M-Monthly  
 Capitation  
 Payment  
 (Dialysis)  
 N-Kidney Donor  
 P-Lump Sum  
 purchase of DME  
 R-Rental of DME  
 T-Psychological  
 Therapy  
 U-Occupational  
 V-Pneumococcal  
 Vaccine  
 W-Physical  
 Therapy  
 Y-Second opinion  
 on Elective  
 Surgery  
 Z-Third opinion  
 on Elective  
 Surgery

10	PROC_CD	68	HCPCS PROC CODE	Character	5	HCPCS code used to process claim
11	PROC_CD1	69A	PROC CODE MODIFIER 1	Character	2	Procedure
12	PROC_CD2	69B	PROC CODE MODIFIER 2	Character	2	Code modifier 1 and 2 used to process the claim
13	PLAC_E_SE	76	PLACE OF SERVICE	Character	2	Field denotes the place of service. 11-Office 12-Home 21-Inpatient Hospital 22-Outpatient Hospital 23-Emergency Room Hospital 24-Ambulatory Surgical Center 25-Birthing Center

26-Military  
Treatment Facility  
31-Skilled  
Nursing Facility  
32-Nursing  
Facility  
33-Custodial Care  
Facility  
34-Hospice  
41-Ambulance -  
Land  
42-Ambulance -  
Air  
51-Inpatient  
Psychiatric  
Facility  
52-Psychiatric  
Facility Partial  
Hospitalization  
53-Community  
Mental Health  
Center  
54-Intermediate  
Care  
Facility/Mental  
Retarded  
55-Residential  
Substance Abuse  
Treatment Facility  
56-Psychiatric  
Residential  
Treatment Center  
61-Comprehensive  
Inpatient  
Rehabilitation  
Facility  
62-Comprehensive  
Outpatient  
Rehabilitation  
Facility  
65-End Stage  
Renal Disease  
Treatment  
71-State or local  
Public Health  
Clinic  
72-Rural Health  
Clinic  
81-Independent  
Laboratory

						99-Other Skilled Facility
14	NUMB_SER	80	NUMBER OF SERVICES	Numeric	3	Total number of services processed for this line item
15	UNITS_SE	66	UNITS	Numeric	3	Total units associated with services needing unit reporting such as miles, anesthesia, time units, volume of oxygen or blood
16	FROM_DT	77	FIRST EXPENSE DATE	Numeric	6	Beginning date of service
17	TO_DATE	78	LAST EXPENSE DATE	Numeric	6	Ending date of service
18	EOMB_COD	81	EOMB ACTION CODE	Character	2	Codes used on EOMB and reported in MCM §7012
19	SUBM_CHA	70	SUBMITTED CHARGE	Numeric	7	Total submitted charge for this line item
20	ALLW_CHA	71	ALLOWED CHARGE	Numeric	7	Total allowed charge for this line item
21	PD_PATIE	91	REIMBURSEMENT PATIENT	Numeric	7	Amount of payment being made to patient
22	PD_PROVIDER	92	REIMBURSEMENT PROVIDER	Numeric	7	Amount of payment being made to provider
23	DEDUCT	93	CASH DEDUCTIBLE APPLIED	Numeric	3	Charged to beneficiary

24	PMT_ DNL	18	PAYMENT, DENIAL CODE	Character	1	Code for payment denial. Shows who payment was made to or if claim was denied. 0-Denied 1-Physician/Supplier 2-Beneficiary 3-Both physician, supplier and beneficiary 4-Hospital (hospital based physicians) 5-Both hospital and beneficiary 6-Group Practice Prepayment Plan 7-Other entries (e.g. Employer, union) 8-Federally funded entities 9-PA services A-Beneficiary under limitation of liability B-Physician/Supplier under limitation of liability X-MSP cost avoided Y-IRS/SSA data match project MSP cost avoided
25	PHYS- IDENT	5	UPIN- REFERRING	Character	6	UPIN (Unique Physician Identification Number of Referring PHYS)
26	SUPP- IDENT	100	UPIN- SUPPLIER	Character	6	UPIN (of Physician Supplier Actually Performing/Providing the Service)

27	DIAG NOSIS	45A	DIAG CODE PRIMARY	Character	5	Diagnosis Code Primary
28	DIAGS EC	45B	DIAG CODE 1ST SECONDARY	Character	5	Diagnosis Code First Secondary
29	DIAG2 SEC	45C	DIAG CODE 2ND SECONDARY	Character	5	Diagnosis Code Second- Secondary.

# Medicare Program Integrity Manual

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## **Exhibit 1 B Definitions {tc \l1 "1 B Definitions }**

### **A**

#### **Abuse**

Billing Medicare for services that are not covered or are not correctly coded.

### **B-C**

#### **Carrier**

The Carrier is an entity that has entered into a contract with HCFA to process Medicare claims under Part B for non-facility providers (e.g., physicians, suppliers, laboratories). Durable Medical Equipment Regional Carriers (DMERCs) are those carriers that HCFA has designated to process DME claims.

#### **Contractor**

Contractor includes all intermediaries, carriers, DMERCs, RHHIs, and PSCs.

### **D-E**

#### **Department of Justice (DOJ)**

Attorneys from DOJ and the United States Attorney Offices have, under the memorandum of understanding, the same direct access to contractor data and records as OIG and the FBI. (See Chapter 1, §5.1.1) DOJ is responsible for prosecution of fraud civil or criminal cases presented.

### **F**

#### **Federal Bureau of Investigation (FBI)**

Along with OIG, the FBI investigates potential health care fraud. Under a special memorandum of understanding (see PIM Exhibits, § 2.1), the FBI has direct access to contractor data and other records to the same extent as OIG.

#### **Fraud**

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

### **G-H**

#### **Health Care Financing Administration (HCFA)**

HCFA administers the Medicare program. HCFA's responsibilities include managing contractor claims payment, fiscal audit and/or overpayment prevention and recovery and the development and the monitoring of payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery.

## I

### **Inpatient hospital claims**

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. For benefit integrity purposes, claims for inpatient hospital services, hospital "swing" bed services, hospital-based ASC services, and procedures on the ASC list (see PIM Chapter 6) performed in the hospital outpatient hospital setting are reviewed by Peer Review Organizations, not intermediaries.

### **Intermediary**

The intermediary is a public or private agency or organization that has entered into an agreement with HCFA to process Medicare claims under both Part A and Part B for institutional providers (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPT, occupational therapy, speech pathology providers, and ESRD facilities). Regional Home Health Intermediaries (RHHIs) are those FIs that HCFA has designated to process Medicare claims received from Home Health and Hospice providers.

## J-K-L

### **Local Medical Review Policy (LMRP)**

LMRPs are those policies used to make coverage and coding decisions in the absence of specific statute, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

## M

### **Misrepresented**

A deliberate false statement made, or caused to be made, that is material to entitlement or payment under the Medicare program.

## N

### **Noncovered (Not Covered)**

Noncovered services are those for which there is no benefit category, services that are statutorily excluded (other than §1862 (A)(1)(a)), or services that are not reasonable and necessary under §1862 (A)(1)(a).

# O

## **Office of Audit Services (OAS)**

OAS conducts comprehensive audits to promote economy and efficiency and to prevent and detect fraud, abuse, and waste in operations and programs. OAS may request data for use in auditing aspects of Medicare and other Health and Human Service (HHS) programs, and is often involved in assisting OIG/OI in its role in investigations and prosecutions.

## **Office of Civil Fraud and Office of Administrative Adjudication (OCFAA)**

The OCFAA is responsible for coordinating activities that result in the negotiation and imposition of CMPs, assessments, and other program exclusions. It works with the Office of Investigations, Office of Audit Services (OAS), HCFA, and other organizations in the development of health care fraud and exclusion cases.

## **Office of Inspector General (OIG)**

OIG investigates suspected fraud or abuse and performs audits and inspections of HCFA programs. In carrying out its responsibilities, OIG may request information or assistance from HCFA and its contractors, including PROs. OIG has access to HCFA's files, records, and data as well as those of HCFA's contractors. OIG investigates fraud, develops cases, and has the authority to take action against individual health care providers in the form of CMPs and program exclusion, and to refer cases to the DOJ for criminal or civil action. OIG concentrates its efforts in the following areas:

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;
- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;
- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;
- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- Collecting and analyzing Medicare contractor and State Medicaid agency-produced information on resources and results; and,
- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

## **Office of Investigations (OI)**

The Office of Investigations (OI), within OIG, is staffed with professional criminal investigators and is responsible for all HHS criminal investigations, including Medicare fraud. OIG/OI investigates allegations of fraud or abuse whether committed by contractors, grantees, beneficiaries, or providers of service (e.g., fraud allegations involving physicians and other providers, contract fraud, and cost report fraud claimed by hospitals).

OIG/OI presents cases to the United States Attorney's Office within the Department of Justice (DOJ) for civil or criminal prosecution. When a practitioner or other person is determined to have failed to comply with its obligations in a substantial number of cases or to have grossly and flagrantly violated any obligation in one or more instances, OIG/OI may refer the case to OCFAA for consideration of one or both of the following sanctions:

- An exclusion from participation in the Medicare program or any State health care programs as defined under §1128(h) of the Social Security Act (the Act); or
- The imposition of a monetary penalty as a condition to continued participation in the Medicare program and State health care programs.

## **Offset**

Withholding payment from a provider of an established, non-Medicare overpayment

# **P**

## **Peer Review Organizations**

The Peer Review Improvement Act of 1982 established the Utilization and Quality Control Peer Review Organization (PRO) program. The (HCFA) contracts with independent physician organizations in each State to administer the PRO program. Their purpose is to ensure that the provisions of the Act are met. Under their contracts with HCFA, PROs are required to review the medical services provided to Medicare beneficiaries in settings such as acute care hospitals, specialty hospitals, or ambulatory surgical centers.

The PRO program is intended to ensure that medical care furnished to Medicare beneficiaries is medically necessary and reasonable, is provided in the most appropriate setting, and meets professionally accepted standards of quality.

## **Program Safeguard Contractor (PSC)**

The PSC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a single contract.

## **Providers**

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, DMERCs, and RHHIs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

## Q- R

### Recoupment

Withholding payment from a provider of an established, Medicare overpayment.

Suspension of payment differs from offset and recoupment in that, at the time payment is suspended, the amount of the overpayment is not yet known. Once an overpayment amount is established, the overpayment is recovered by first applying the payments that were suspended and then by initiating other recoupment procedures.

### Reliable Information

Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists; for example, that claims are or were false or were submitted for non-covered or miscoded services. Reliable information of fraud exists if the following elements are found:

- **The allegation is made by a credible person, a credible source.** The source is knowledgeable and in a position to know. The source experienced or learned of the alleged act first hand, i.e., saw it, heard it, read it, etc. The source is more credible if the source has nothing to gain by not being truthful. The source is competent; e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who “heard” that the provider is defrauding Medicare may not be a particularly credible source;
- **The information is material.** The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable. An example would be instructions handwritten by the provider delineating how to falsify claim forms;
- **The act alleged is not likely the result of an accident or honest mistake.** For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or
- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or HCFA, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

## S

### **Services**

Medical care, items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42CFR 400.202). In other sections of Medicare manuals and remittance advice records, the term item/service is used. However, throughout this manual we will use the term service to be inclusive of item/service. See §1861 of Title 18 for a complete description of services by each provider type.

### **Suspension of Payment**

Suspension of payment is defined in the regulation (42CFR 405.370) as “the withholding of payment by the carrier or intermediary from a provider or supplier of an approved Medicare payment amount before a determination of the amount of overpayment exists.” In other words, contractors have received, processed and approved claims for a provider’s items or services; however, the provider has not been paid and the amount of the overpayment has not been established.

## T-U-V-W-X

## **Exhibit 2 B Requests for Information from Outside Organizations**

Private insurers and Federal and State law enforcement agencies may seek information to further their investigations or prosecutions of individuals or businesses alleged to have committed fraud. In deciding to share information voluntarily or in response to outside requests, the contractor must carefully consider each request ensuring that disclosure does not violate the requirements of the Privacy Act of 1974 (5 U.S.C. 552a).

The Privacy Act affords protection only to individuals. Therefore, there is a privacy issue only when the information pertains to specific persons, e.g., physicians or beneficiaries. In all cases, the contractor is free to share the nature of the scams or fraudulent schemes active in the area.

Contractors may share how they detected the fraudulent practice in general terms, the action being taken, as well as aggregated data showing trends and/or patterns. When there is a question of whether information may be disclosed, contractors request approval from the Privacy Act Coordinator in the RO.

Some information may be released under a "routine use." The information protected by the Privacy Act is referred to as "records", maintained in what is referred to as "systems of records." A "record" is any item, collection, or grouping of information about an individual that is maintained. A "system of records" is a group of records from which information is retrieved by the name of the individual or some other unique identification. The Federal Register notice for the systems of records maintained may be found in the Privacy Act Issuances, 1991 Compilation, Volume 1.

Each system of records specifies the information collected, categories of individuals and records covered by the system, the purpose for which the information is used, and other information. Included are "routine uses," that is, disclosure for purposes for which the data are collected. In other words, routine uses specify who may be given the information and the basis or reason for access that must exist. Routine uses vary by system of records and decisions concerning the applicability of a routine use lies solely in the purview of the system's manager for each system of records.

### **A - Requests from Private, Non-Law Enforcement Agencies**

Generally, unless the request is subject to a routine use, contractors can furnish information on the scheme, where it is operating, and specialties involved. The name of a suspect is not disclosable. Contractors refer these requests to the RO.

### **B - Requests from Medicare Contractors, PROs, Medicare State Survey and Certification Agencies, Medicaid Fraud Control Units and State Attorney General Offices**

Contractors may furnish requested specific information on ongoing fraud investigations to any of these agencies. If the request concerns cases already referred to the OIG/OI, contractors refer the requesting agency to the OIG/OI.

### **C - Requests from Medicaid Fraud Control Unit**

Under current Privacy Act requirements applicable to program integrity investigations, contractors are permitted to respond to requests for information on current investigations.

## **D - Respond to Requests from OIG/OI and RO for Data and Other Records**

Contractors provide the RO or OIG/OI with requested information and maintain cost information related to fulfilling these requests. The contractors provide the OIG/OI direct, electronic access to Medicare data. If major/costly systems enhancements are required to fulfill a request, contractors discuss the request and the cost with the RO before fulfilling the request. These requests generally fall into one of the following categories:

**Priority I** - This type of request is a top priority request which requires a quick turnaround. The information is essential to the prosecution of a provider. Information or material is obtained from the contractor's files. Examples include, but are not limited to, copies of claims, beneficiary and provider payment histories, utilization data, provider contact reports, and educational/warning letters.

Contractors respond to such requests within 30 calendar days, where possible. If that time span cannot be complied with, the contractors notify the requesting office as soon as possible after receiving the request, but no later than 30 days. Contractors include an estimate of when all requested data will be supplied.

**Priority II** - This type of request is less critical than a Priority I request. Development requests may require review or interpretation of numerous records, extract records from retired files in a warehouse or other archives, or solicit information from other sources. Examples include, but are not limited to, requests to conduct telephone surveys of a sample of beneficiaries, reviews of medical records for medical necessity by the medical review component and/or documentation of services, and educational contacts.

Contractors respond to such requests within 45 calendar days, when possible. If that time span cannot be complied with, the contractors notify the requesting office within the 45-day time frame and include an estimate of when all requested data will be supplied.

### **2.1 - Memorandum of Understanding Regarding Requests from FBI/DOJ{tc \\2 "2.1 B Memorandum of Understanding Regarding Requests from FBI/DOJ}**

A memorandum of understanding (MOU) was signed April 29, 1994 by the DOJ, the OIG, and HCFA. The MOU replaces and supersedes all memoranda, letters, instructions, or MOUs issued previously on the subject of FBI/DOJ access to Medicare contractor data. It allows contractors, upon written request, to furnish information directly to the FBI and DOJ that historically had to be routed through OIG. It is intended to ensure that FBI agents and DOJ attorneys have timely access to information and records maintained by Medicare carriers and fiscal intermediaries. At the same time, it seeks to provide sufficient safeguards to assure that contractors are not overly burdened with data requests and are able to meet the MOU requirements within current operating budget. The MOU also provides for law enforcement agencies' cooperation in providing information necessary to detect and deter fraud and abuse and to safeguard the Medicare Trust Fund from inappropriate payouts.

The MOU does not change how contractors refer cases. The contractors continue to refer all cases to OIG. OIG will refer cases to the FBI, as it deems appropriate. Contractors do not refer cases to the FBI or other law enforcement agency, including the MFCU, without the prior approval of OIG/OI.

## **A - Applicability of MOU to Other Federal Agencies**

The MOU applies only to the DOJ, including U.S. Attorneys, and the FBI. Requests from other agencies, such as the Postal Inspection Service or Drug Enforcement Administration, should continue to be referred to the appropriate OIG/OI.

## **B - Focal Point for Processing Requests**

The Medicare Fraud Unit Manager is the focal point for processing information requests received from law enforcement agencies. The fraud unit manager:

- Serves as the contact person for all information requests;
- Provides timely written acknowledgment of receipt of all information requests;
- Coordinates the efforts of all components within operations involved in compiling the requested information;
- Responds timely to all information requests by providing the requested information or contacting the requesting agency in writing and explaining the reasons why compliance cannot be made; and
- Requests the intervention of the Regional Office (RO) for Medicare, when necessary, providing a written explanation as to why the contractor and the requesting official cannot reach an accommodation.

## **C - Duplicate Requests for Information**

The DOJ and OIG will exchange information on cases they are working on to prevent duplicate investigations. If contractors receive duplicate requests for information, the contractors notify the requestors. If the requestors are not willing to change their requests, contractors ask the RO for assistance.

## **D - Data Covered by MOU**

Contractors should comply with reasonable written requests from the FBI and DOJ, including Assistant U. S. Attorneys (AUSAs), for data and records related to a specific investigation of an individual or group of individuals, or entity or group of entities. In addition, while "fishing expeditions" are not permitted, requests for information on a reasonable number of providers whose identity is unknown may be appropriate when these requests target particular practices that DOJ/FBI believe may be fraudulent. If a DOJ attorney or FBI agent wishes to make such a request, the attorney or agent first discusses it with contractor personnel to ascertain whether the contractor has information corroborating or negating the DOJ/FBI information and to determine

whether the request presents an unreasonable burden on the contractor, or to determine whether the request can be met in a different manner.

Acceptable data requests include, but are not limited to:

- Information contained on claim forms and other records maintained on individual providers or suppliers;
- Billing procedure updates and other Medicare publications furnished to providers or suppliers;
- Contractor correspondence to and from providers/suppliers;
- Billing history of beneficiaries;
- Analysis performed by Fraud and Abuse Units; and
- Data analysis routinely done by Medicare contractors such as utilization reviews.

### **E - Requests Believed to be Excessive, Beyond the Scope of the MOU, or Otherwise Burdensome or Expensive**

Requests may be received that are believed to be unreasonable because the data being requested:

- Is a "hunting expedition";
- Would be very expensive to generate;
- Appear to be beyond the scope of the MOU; or
- Cannot be furnished in the time requested.

Contractors evaluate the ability to respond to the requests before deciding to commit the required resources. While the MOU assumes that law enforcement agencies and HCFA contractors will cooperate with one another, it does not commit HCFA to fund all requests.

Contractors should try to resolve issues with the agent or attorney making the request if the contractor believes it cannot comply with a request. The contractors explain to the requestor why the request cannot be fulfilled. In many cases, the contractor and the requestor may be able to restructure the request to meet the requestor's needs.

If the contractor is unable to reach agreement, it refers the matter to the appropriate RO for Medicare. The RO reviews the request, obtains additional information as necessary, and makes a final decision on the request. The RO will promptly notify the contractor and the requestor of the decision. While most requests for data will be permitted under the Privacy Act, contractors raise any concerns regarding filling requests with the RO.

Contractors consult with the RO if there is receipt of an otherwise reasonable request that will be very costly to fulfill or will affect its ability to perform other Medicare requirements. HCFA will

fund reasonable requests to the extent funds are available. If funds are not available, such requests may be denied. Contractors notify the RO, and obtain their approval before denying a request because of funding.

## **F - Privacy Act Responsibilities**

The MOU is consistent with the Privacy Act. Therefore, requests that conform to the MOU do not violate the Privacy Act. The Privacy Act of 1974 requires federal agencies that collect information on individuals that will be retrieved by the name or another unique characteristic of the individual to maintain this information in a system of records.

The Privacy Act permits disclosure of a record, without the prior written consent of an individual, if at least 1 of 12 disclosure provisions apply. Two of these provisions, the "routine use" provision and/or the "law enforcement" provision, may apply to requests from DOJ and/or FBI.

First, disclosure is permitted under the Privacy Act if a routine use exists in a system of records.

Both the "Intermediary Medicare Claims Records," System No. 09-70-0503 and the "Carrier Medicare Claims Records," System No. 09-70-0501, contain a routine use which permits disclosure to:

"The Department of Justice for investigating and prosecuting violations of the Social Security Act to which criminal penalties attach, or other criminal statutes as they pertain to Social Security Act programs, for representing the Secretary, and for investigating issues of fraud by agency officers or employees, or violation of civil rights."

The "HCFA Utilization Review Investigatory File," System No. 09-70-0527, contains a routine use which permits disclosure to "The Department of Justice for consideration of criminal prosecution or civil action."

This routine use is more limited than the above mentioned routine use, in that it is only for "consideration of criminal or civil action." It is important to evaluate each request based on its applicability to the specifications of the routine use.

In most cases, these routine uses will permit disclosure from these systems of records; however, each request should be evaluated on an individual basis.

Disclosure from other HCFA systems of records is not permitted unless a routine use exists or 1 of the 11 other disclosure provisions of the Privacy Act applies.

The law enforcement provision may apply to requests from the DOJ and/or FBI. This provision permits disclosure "to another agency or to an instrumentality of any jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of the agency or instrumentality has made a written request to the agency which maintains the record specifying the particular portion desired and the law enforcement activity for which the record is sought."

The law enforcement provision may permit disclosure from any system of records if all of the criteria established in the provision are satisfied. Again, requests should be evaluated on an individual basis.

To be in full compliance with the Privacy Act, all requests must be in writing and must satisfy the requirements of the disclosure provisions. Contractors refer requests that raise Privacy Act concerns and/or issues to the RO for further consideration.

### **2.1.1 - Reporting Requirements**

Contractors maintain a record of each request received, including those from the OIG and collect the following information:

- The name and organization of the requestor;
- The date of the written request (all requests must be in writing);
- The nature of the request;
- Any subsequent modifications to the request;
- Whether the RO had to intervene and the outcome (request fulfilled or not fulfilled); and
- The cost of furnishing a response to each request.

Report the data to the RO when requested. This data will be used to monitor and evaluate the MOU and to assess budget requirements.

### **2.1.2 - Periodic Exchange of Information Among OIG, FBI, DOJ, Attorneys, and Medicare Contractors**

The MOU specifically provides for periodic meetings between DOJ, OIG, regional officials, and Medicare contractors to be held at the local level. If contractors currently have regularly scheduled meetings with the OIG to discuss current investigations, the contractors should invite the RO, FBI and DOJ attorneys to these meetings. If contractors do not currently hold such meetings, the contractors should arrange to do so. These meetings should be held at least quarterly. They serve an important role in ensuring effective communication between the contractor, OIG/OI, and the DOJ/FBI.

Contractors do not need the permission of the OIG to schedule and conduct these meetings. Moreover, the OIG does not have to be present at meetings, although contractors should invite them to the meetings.

In several parts of the country, U.S. Attorneys and the FBI have formed Health Care Fraud Working Groups. The working groups meet periodically to discuss current investigations. Although Medicare contractor fraud staff may not have access to all of the information shared by the law enforcement community, the U.S. Attorneys and FBI should be willing to share

information on the particular scheme, how it was detected, and the current status of the investigation.

## **Exhibit 3 B Description of CAC Members**

### **3.1 B Physicians**

Medicare defines physicians as:

- Doctors of medicine;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Chiropractors;
- Doctors of podiatry or surgical chiropody; and
- Doctors of optometry.

Do not include other practitioners on this committee.

Carriers select committee representatives from names recommended by State medical societies and specialty societies. If the CMD is concerned because of identified utilization/MR problems with an individual who has been recommended as a committee representative, the CMD should discuss the recommendation with the nominating body. They must maintain confidentiality of the specifics of the situation in any discussion.

If there is no organized specialty society for a particular specialty, the CMD should work with the State medical society to determine how the specialty is to be represented. Encourage each State medical society and specialty society to nominate representatives to the CAC.

If there are multiple specialty societies representing a specialty, select only one representative. Encourage specialty societies to work together to determine how a representative is selected and how that representative communicates with each society.

CMDs who become committee members or are appointed or elected as officers in any state or national medical society or other professional organization must provide written notice of membership, election, or appointment to CO and RO, as well as to the CAC within 3 months of the membership, election, or appointment effective date. This notice can be provided as part of the CAC minutes if the CMD chooses to give CAC notice via the CAC meeting forum, provided that the CAC meeting is held within the 3-month notice period.

Attempt to include, as members of your CAC, physician representatives from each of the following groups:

- State medical and osteopathic societies (president or designee);

- National Medical Association (representative of either the local or State chapter or its equivalent, if one exists); and
- Medicare managed care organizations. In order to enhance the consistency of decision making between Medicare managed care plans and traditional fee-for-service, Medicare managed care organizations shall also have representation on the CAC. The number of managed care representatives on the CAC should be based on the Medicare penetration (enrollment) rates for that State; one representative for those States with penetration rates of less than 5 percent and two representatives for those States with penetration rates of 5 percent or higher. The State HMO association should periodically submit nominees for membership on the CAC.
- Physician representatives for each of the following: 1) Chiropractic; 2) Maxillofacial/Oral surgery; 3) Optometry; and 4) Podiatry.

Include one physician representative of each of the following clinical specialties and sub-specialties:

- Allergy;
- Anesthesia;
- Cardiology;
- Cardiovascular/Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Family Practice;
- Gastroenterology;
- Gerontology
- General Surgery;
- Hematology;
- Internal Medicine;
- Infectious Disease;
- Medical Oncology;
- Nephrology;

- Neurology;
- Neurosurgery;
- Nuclear Medicine
- Obstetrics/Gynecology;
- Ophthalmology;
- Orthopedic Surgery;
- Otolaryngology;
- Pathology;
- Pediatrics;
- Peripheral Vascular Surgery;
- Physical Medicine and Rehabilitation;
- Plastic and Reconstructive Surgery;
- Psychiatry;
- Pulmonary Medicine;
- Radiation Oncology;
- Radiology;
- Rheumatology; and
- Urology

The CMD must work with the societies to ensure that committee members are representative of the entire service area and represent a variety of practice settings.

### **3.2 B Clinical Laboratory Representative**

In addition to the representatives for physician clinical specialties, include an individual to represent clinical laboratories. This individual may also be a physician. Consider recommendations from national and local organizations that represent independent clinical laboratories in making this selection.

### **3.3 B Beneficiaries**

Include two representatives of the beneficiary community:

- \$ One based on recommendations made by an association(s) representing issues of the elderly (e.g., coalitions for the elderly, senior citizen centers, etc.), and
- \$ One based on recommendations made by an association(s) representing the disabled.

One role of the beneficiary representatives is to communicate with other beneficiary groups that have an interest in LMRP.

### **3.4 B Other Organizations**

Carriers invite the following to be members:

- A representative from the State Hospital Association;
- PRO Medical Director;
- Intermediary Medical Director;
- Medicaid Medical Director (or designee); and
- A representative of an association representing administrative practices, such as the American Group Practice Association or the Medical Group Management Association.

Welcome congressional staff to attend as observers. Send notice to them of the agenda and dates. Invite representatives of the RO to attend and participate.

### **Exhibit 4 B Reliable Information**

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or

- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or HCFA, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

## **Exhibit 5 - Background Information for Contractor Staff When IRP is Questioned**

Section 203(b)(1) of the Health Insurance Portability and Accountability Act of 1996 allows the federal government to pay a reward to individuals who report evidence of suspected fraud and abuse against the Medicare program. Implementing regulations, issued on June 8, 1998, were effective on July 8, 1998, and provide that a complainant may be rewarded up to 10 percent of the amount recovered, but not more than \$1,000. Not everyone is eligible for the reward, though. To be eligible for a reward:

- \$ The information you give has to lead to a recovery of at least \$100;
- C The suspected fraud must be acts or omissions that are grounds for the government to impose sanctions provided under certain provisions of the law;
- C There isn't another reward that you qualify for under another government program;
- C You must not have participated in the sanctionable offense with respect to which payment is being made;
- C If the person or organization is already under investigation, you will not be eligible for a reward; and
- C You are not an immediate family member or an employee of the Department of Health and Human Services, its contractors or subcontractors, the Social Security Administration, the Office of the Inspector General, a State Medicaid Agency, the Department of Justice, the FBI, or any other federal, State, or local law enforcement agency at the time he or she came into possession, or divulged information leading to a recovery of Medicare funds.

You'll receive a letter from us acknowledging that we have received your complaint. Some investigations take a long time to complete, and may take several months or years to resolve. You'll be notified by letter of your eligibility to receive a reward after the Medicare funds have been recovered. If you do receive a reward for this information you may be expected to pay any applicable state and federal taxes.

### **5.1 - Reward Eligibility Notification Letter**

Dear \_\_\_\_\_:

You are eligible for a reward as part of the Medicare Incentive Reward Program for telling us about Medicare fraud and abuse.

To claim your reward, please fill out the enclosed form and return it to [contractor information] in the enclosed envelope. You have **one year** from the date of this letter to claim your reward.

In the case of death or incapacitation of the person reporting the potential fraud, a legal representative of that person may claim the reward on his or her behalf when evidence is submitted to justify the claim.

If it is later found that you received the reward caused by your misrepresentation of the facts, all monies paid to you must be returned to Medicare. If you have questions, please contact [contractor information].

Sincerely,

[Contractor Information]

Enclosures

## 5.2 - Reward Claim Form{tc \12 "5.2 ? Reward Claim Form}

[To be completed by contractor.]

Provider/Supplier Name

\_\_\_\_\_   
 Case Number

### REWARD CLAIM FORM

Date

Dear [Contractor Information]:

I am claiming the reward for providing information about Medicare fraud by filling out this form as it applies to me. My signature verifies that I am a proper recipient of the incentive reward or that I am the legal representative of the proper recipient of the reward. I also understand that the reward must be repaid by the recipient if it is later determined that the reward should not have been received.

### CLAIMANT INFORMATION

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_

City                      State                      Zip Code

---

Telephone Number

---

Claimant (or Representative) Signature

### REPRESENTATIVE INFORMATION

If the intended recipient of the reward has become incapacitated or has died, his or her executor, administrator, or other legal representative may collect the reward on the individual's behalf or for the individual's estate. In addition to submitting this letter, please also submit certified copies of letters testamentary, letters of administration, or other similar evidence to show your authority to claim the reward. In the space provided below, please submit your name and the mailing address where the check should be sent if that address differs from the information stated above.

---

Name

---

Street Address

---

City                      State                      Zip Code

---

Telephone Number

### **5.3 - How to Use the IRP Tracking System**

Selected IRP screen exhibits may be viewed from the PIM whenever "**Click here to view the selected screen**" is indicated in bold.

After you log on to the Winframe, you will see the IRP Tracking group icon. Double click on that icon, then double click on the IRP Tracking to run the application. The first screen IRP Menu will appear.

**Click here to view an exhibit of the IRP Menu screen.**

### **A - Screen Use**

From the IRP menu screen, click on the item you would like to select. Reference §§5.4 through 5.9 below for explicit instructions on how to use every menu option of the IRP system.

### **B - Options**

1. Pending Case List - This function allows you to view all of the pending cases in the system. See §5.4 below for details on this option.
2. Pending List By Contractor - This function allows you to view all of the pending cases that are listed by each contractor ID number. See §5.5 below for details on this option.
3. New Case - This function allows you to enter a new case into the system. See §5.6 below for details on this option.
4. Closed Case List - This function allows you to view all of the closed cases in the system. See §5.7 below for details on this option.
5. Closed Case List By Contractor - This function allows you to view all of the closed cases which are listed by each contractor's ID number. See §5.8 below for details on this option.
6. Report Menu - This function allows you to open the report menu that contains all available predefined reports.

## **5.4 - Section I: Pending Case List Screen**

**Click here to view an exhibit of the Pending Case List Screen.**

View Case- After you select a case number, you can double click on the view case button on the bottom of the screen to view the case detail screen of the case selected. From the case detail screen you may:

1. View Comments - You may enter/edit contractor comments or view HCFA comments. DO NOT EDIT HCFA COMMENTS. You may save comments or save/close form.
2. Edit Case - You may select view/edit comments and enter/edit contractor comments or view HCFA comments. DO NOT EDIT HCFA COMMENTS. You may save comments or save/close form. You may also select enter/edit provider to access the provider detail screen. From the provider detail screen you may click on 1) add new provider; 2) delete provider; 3) edit provider; or 4) enter/edit an allegation against a provider. To edit the provider appearing on the screen, click on the edit provider button. You may click on next provider or previous provider to find the one that you want to edit. To enter/edit an allegation, click on the allegation button to get to the view allegations screen. Select the case desired and you may add or delete an allegation or cancel this function.
3. View Report - Click on the view report to get to the case report menu. You may now view the details of the selected case.

## **5.5 - Section II: Pending Case List by Contractor Screen**

You may perform the same functions as in §5.4 (§I) above: Pending Case List however, information will be provided specific to the contractor ID number entered.

## **5.6 - Section III: New Case**

**Click here to view an exhibit of the New Case Screen.**

Click on the new case button to get the new case screen. You must enter a FID number at this time to enter new case information. You can move from one data field to another by either using the Tab key or the mouse to move the cursor to that data field. After entering all available information, you must remember to click on the enter provider information to access the provider detail screen and click on the enter complainant information to access the complainant detail screen. You may also edit the provider information or complainant information using this same approach. If the provider number is not entered at this time, the system will not allow you to save this provider information. The case number and complainant's first, middle initial and last name must be entered to allow you to save the complainants information.

1. Provider Detail - Enter provider information then click the enter allegation button to get to the view allegations screen. At this point, you may add an allegation, delete an allegation, or cancel the screen. An allegation is added by typing in an allegation code next to the provider number and then clicking on "OK". You may exit the screen by clicking on the ok-save edits button.
2. Complainant Detail - Enter complainant information then close screen.

## **5.7 - Section IV: Closed Case List**

**Click here to view an exhibit of the Closed Case List Screen.**

You may perform the same functions as in §5.4 (§I) above: Pending case list however, information will be provided only for closed cases.

## **5.8 - Section V: Closed Case List by Contractor**

You may perform the same functions as in §5.5 (§II) above: Pending case list by contractor however, information will be provided for closed cases specific to the contractor ID number entered.

## **5.9 - Section VI: Report Menu**

**Click here to view an exhibit of the Report Menu Screen.**

**Click here to view an exhibit of the IRP Cases List Screen.**

**Click here to view an exhibit of the View Case Detail Screen.**

**Click here to view an exhibit of the Edit Case Detail Screen.**

**Click here to view an exhibit of the Comments Screen.**

**Click here to view an exhibit of the Provider Detail Screen.**

**Click here to view an exhibit of the Provider Edit Detail Screen.**

**Click here to view an exhibit of the View Allegations Screen.**

**Click here to view an exhibit of the View Edit Allegations Screen.**

**Click here to view an exhibit of the View Complainant Detail Screen.**

**Click here to view an exhibit of the Case Report Screen.**

The report menu provides a variety of management reports in brief format and detailed format. Click on the report menu from the main IRP menu. Select the type of report desired from the following list:

**A - BRIEF LIST**

- All Cases;
- Pending Cases;
- Closed Cases;
- Rewarded Cases;
- Recovery From Ten Thousand Up; and
- Notified But Not Rewarded

**B - DETAIL LIST**

- All Cases

**C - LIST BY CONTRACTOR**

- All Cases- Brief; and
- All Cases- Detailed;

**IRP System** [Close] [Print] [Find] [Sort] [Filter]

File Edit Options Help

## Pending Case List

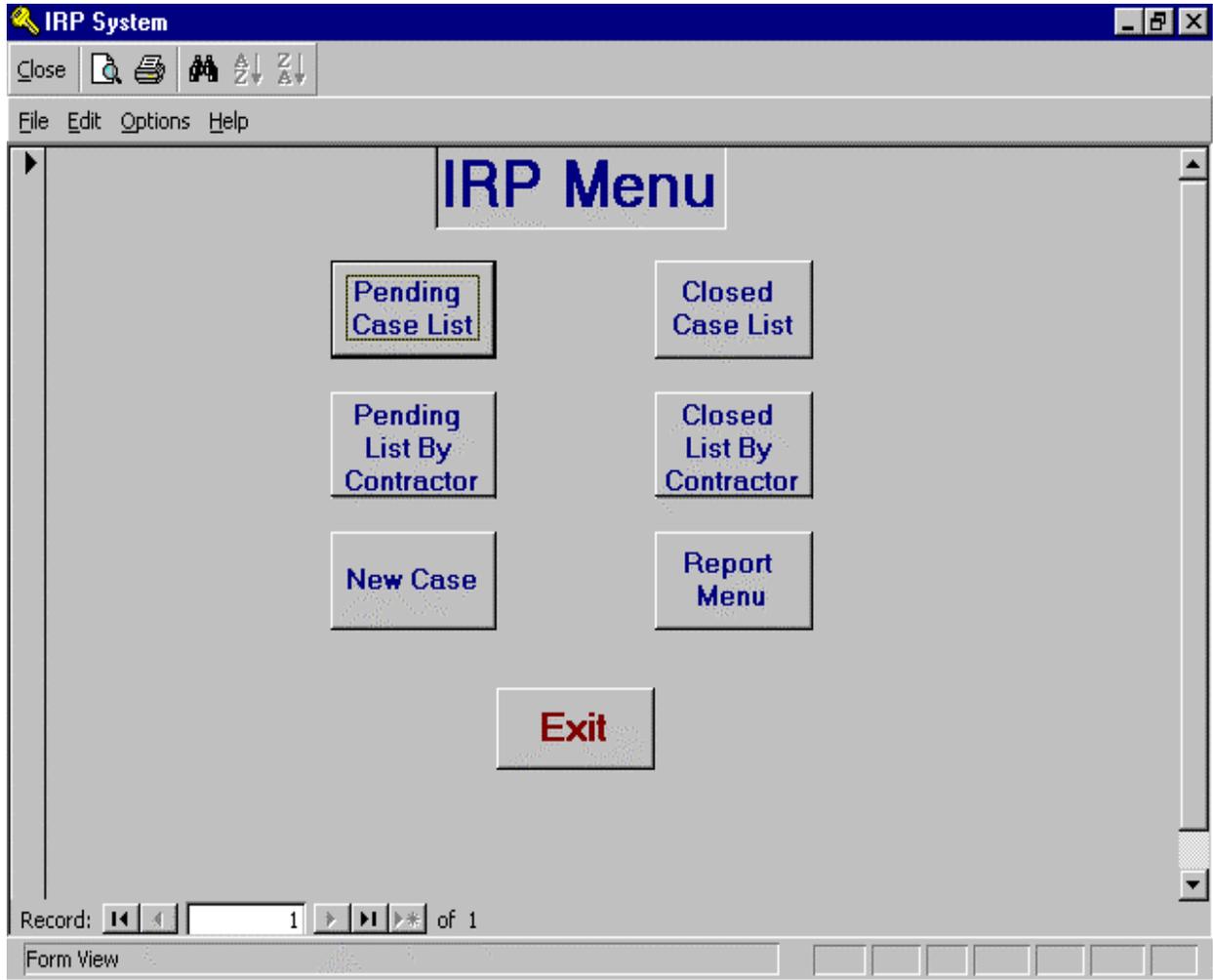
FID No	Complainant Last Name	Provider Name	Date Entered	Date of Complaint	Contractor ID
▶ A54545454	Adrie	Blue Cross Blue Shield	07/06/1998	12/10/1998	23489
A54545454	Adrie	Columbia Provider Health care	07/06/1998	12/10/1998	23489
A54545454	McCain	Blue Cross Blue Shield	07/06/1998	10/03/1998	23489
A54545454	McCain	Columbia Provider Health care	07/06/1998	10/03/1998	23489
A54545454	Tran	Blue Cross Blue Shield	07/06/1998	12/10/1998	23489
A54545454	Tran	Columbia Provider Health care	07/06/1998	12/10/1998	23489
test6	Test6				
test6	Test6				
test6	Test6				
Test7	Kendal			12/10/1998	
Test7	Kendal			12/10/1998	
Test7	Kendal			12/10/1998	

[View Case](#)

Record: [First] [Previous] [1] [Next] [Last] of 12

FID Number (same as FID case number in the FID System) [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**NOTE:** For security reasons, this system will not allow you to delete a case after it is entered into the system. If the need arises, you may contact Binh Nguyen at (410) 786-3682 for assistance.





## Closed Case List

FID No	Complainant Last Name	Provider Name	Date Entered	Date of Complaint	Date Closed	Contractor ID
▶ Test4					12/08/1997	
Test4					12/08/1997	

[View Case](#)

Record: 1 of 2

FID Number (same as FID case number in the FID System)

**IRP System** [Close] [Find] [Print] [Help] [A-Z] [Z-A]

File Edit Options Help

## New Case

**FID Number:**  **OIG Number:**  **DOJ Number:**   
**Contractor Case Number:**  **Date Entered:**   
**Date Referred To OIG:**  **Date Updated:**

---

**Contractor Info:**  
**ID:**  **Name:**   
**Address:**  **Phone:**

---

**Overpayment Identified:**  **Overpayment Recovered:**  **Closed Date:**   
**Overpayment Assessed:**  **Date Notified:**

**Rewarded**  **Date Rewarded:**  **Amount Rewarded:**   
**Check No:**

**Resolution:**

---

**Contractor Comment:**

Record: [First] [Previous]  [Next] [Last] of 1

FID Number (same as FID case number in the FID System)

# Report Menu

Brief List Of:

- All Cases
- Pending Cases
- Closing Cases
- Rewarded Cases
- Recovery From Ten Grand Up
- Notified But No Rewarded

Detail List Of:

- All Cases

List By Contractor:

- All Cases - Brief
- All Cases - Detail

Main Menu

### View Case Detail

**FID Number:**  **OIG Number:**  **DOJ Number:**   
**Contractor Case Number:**  **Date Entered:**  **View Comments**  
**Date Updated:**  **Date Referred To OIG:**

**Contractor Info:** **Edit Case**  
**ID:**  **Name:**   
**Address:**  **Phone:**  **View Report**

**Overpayment Identified:**  **Overpayment Recovered:**  **Closed Date:**   
**Overpayment Assessed:**  **Date Notified:**   
**Rewarded:**  **Date Rewarded:**  **Amount Rewarded:**   
**Check No:**   
**Resolution:**

**Complainant Info:** **Prev** **Next**  
**Name:**    **FID No:**

### Edit Case Detail

**FID Number:** 
**OIG Number:** 
**DOJ Number:**   
**Contractor Case Number:** 
**Date Entered:**   
**Date Updated:** 
**Date Referred To OIG:**

**Contractor Info:**

**ID:** 
**Name:**   
**Address:**   
    
**Phone:**

View/Edit Comments

Enter/Edit Provider

**Overpayment Identified:** 
**Overpayment Recovered:** 
**Closed Date:**   
**Overpayment Assessed:** 
**Date Notified:**   
**Rewarded:** 
**Date Rewarded:** 
**Amount Rewarded:**   
**Check No:**   
**Resolution:**

**Complainant Info:**

**Name:**   
**FID No:**

Edit Complainant

Prev Next

Record:  of 1 (Filtered)

FID Number (same as FID case number in the FID System) FLTR

### View Case Detail

**FID Number:** 
**OIG Number:** 
**DOJ Number:**   
**Contractor Case Number:** 
**Date Entered:** 
  
**Date Updated:** 
**Date Referred To OIG:**

**Contractor Info:**  
**ID:** 
**Name:** 
  
**Address:**   
  
**Phone:**

**Overpayment Identified:** 
**Overpayment Recovered:** 
**Closed Date:**   
**Overpayment Assessed:** 
**Date Notified:**   
**Rewarded:** 
**Date Rewarded:** 
**Amount Rewarded:**   
**Check No:**   
**Resolution:**

**Complainant Info:**

  
**Name:**   
**FID No:**

Record:       of 1 (Filtered)

### Comments

Save  
Comments

Save / Close  
Form

FIDNO:

- ▶ Contractor Comments:
- HCFA Comments:

**This case has been reported on 10/3/1998**

Region 4 contractor will work on this

### Provider Detail

**Add New Provider**   **Delete Provider**   **Edit Provider**   **Next Provider**   **Previous Provider**

▶ **FID No:**    **Provider Number:**

**Provider Name:**

**Address:**   **Phone:**

**Street:**   

**City:**

**State:**    **Zip:**

**Enter or Edit Allegation Against This Provider**



Enter Allegations

### Edit Provider Detail

OK-Save Edits Cancel

FID No:	A54545454	Provider Number:	111
Provider Name:	Blue Cross Blue Shield		
Address:		Phone:	(215)786-6754
Street:			
City:	Philadelphia		
State:	PA	Zip:	56798

### View Allegations

Current List for this Case/Provider  
use buttons at right to edit

**Add Allegation**   **Delete Allegation**   **Cancel**

FID No	Prov	Allegation(s)	
A54545454	111	105	CERTIFICATION FRAUD
A54545454	222	120	FALSE BILLING SUBMITTED
A54545454	222	301	CONTRACTOR/PROVIDER AGREEMENT(SUSPICION)

Record: [Navigation] 1 of 3 (Filtered)

Unique combination of case/provider/allegation code for allegation subform   FLTR [ ] [ ] [ ] [ ] [ ] [ ]



### Edit Allegations

O.K.

Cancel

FID No	Prov	Allegation(s)										
45454545	111	<table border="1"><tr><td>0</td><td>not entered</td></tr><tr><td>103</td><td>BID RIGGING/PRICE FIXING</td></tr><tr><td>105</td><td>CERTIFICATION FRAUD</td></tr><tr><td>115</td><td>KICKBACKS</td></tr><tr><td>120</td><td>FALSE BILLING SUBMITTED</td></tr></table>	0	not entered	103	BID RIGGING/PRICE FIXING	105	CERTIFICATION FRAUD	115	KICKBACKS	120	FALSE BILLING SUBMITTED
0	not entered											
103	BID RIGGING/PRICE FIXING											
105	CERTIFICATION FRAUD											
115	KICKBACKS											
120	FALSE BILLING SUBMITTED											

Record: 14 of 14

Unique combination of case/provider/allegation code for allegation subform

**IRP System**

File Edit Options Help

Close

# IRP Cases List

Friday, December 11, 1998

<u>FID No</u>	<u>Contractor ID</u>	<u>Contractor Name</u>	<u>Complainant Name</u>			<u>Overpayment Identified</u>	<u>Overpayment Recovered</u>	<u>Date Entered</u>
A54545454	23489	David Ken	Nam	R	Tran	\$345,672.00	\$3,456.00	07/06/1998
A54545454	23489	David Ken	Nam	R	Tran	\$345,672.00	\$3,456.00	07/06/1998
A54545454	23489	David Ken	Keredy	T	McCain	\$345,672.00	\$3,456.00	07/06/1998
A54545454	23489	David Ken	Keredy	T	McCain	\$345,672.00	\$3,456.00	07/06/1998
A54545454	23489	David Ken	Neal		Adrie	\$345,672.00	\$3,456.00	07/06/1998
A54545454	23489	David Ken	Neal		Adrie	\$345,672.00	\$3,456.00	07/06/1998

Ready

### View Complainant Detail

**Add New Complainant**   **Delete Complainant**   **Edit Complainant**   **Next Complainant**   **Prev Complainant**

FID No:    Date of Complaint:

**Complainant Name:**

First:    Mid Initial:    Last:    Phone:

**Address:**

Street:

City:    State:    Zip:

Complainant HIC No:    Complainant SSN:

Record:      of 3 (Filtered)

FID number

**IRP System** [Window Title Bar]

File Edit Options Help [Menu Bar]

[Icons] Close [Toolbar]

# Case Report

Friday, December 11, 1998

---

<b>FID Number:</b> <b>A54545454</b>	<b>OIG Number:</b>	<b>DOJ Number:</b>
<b>Contractor Case Number:</b>	<b>Date Entered:</b> 07/06/1998	
<b>Date Updated:</b> 07/15/1998	<b>Date Referred To OIG:</b>	

---

**Contractor Info:**

<b>ID:</b> 23489	<b>Name:</b> David Ken
<b>Address:</b> 143 Lens Avenue Conschocken PA 18765	<b>Phone:</b> (610)567-8765

---

<b>Overpayment Identified:</b> \$345,672.00	<b>Overpayment Recovered:</b> \$3,456.00	<b>Closed Date:</b>
<b>Overpayment Assessed:</b> \$45,672.00	<b>Date Notified:</b>	
<b>Rewarded:</b> <input type="checkbox"/>	<b>Date Rewarded:</b>	<b>Amount Rewarded:</b>
<b>Resolution:</b>	<b>Check No:</b>	

Ready [Status Bar]

## Exhibit 6 - LMRP Format {tc \11 "6 B LMRP Format }

### Exhibit 6 - LMRP Format {tc \11 "6 B LMRP Format }

Contractors must ensure that all its LMRPs are written in the following format.

Include one of the following in the subject line:

“FI LMRP”;

“CARRIER LMRP”

“RHHI LMRP”

“DMERC”

Subject, Company, Geographical Jurisdiction, Other States to which this LMRP applies (FI LMRP only)	A brief, one line description of the topic or subject matter of the policy. The subject identifies the name of the medical policy. This field is used in the Keyword Search function for researching and drafting policies. To improve identifying your policies, try not to use special characters such as parentheses, slashes, and ellipses in this field.
Policy Number	A unique policy identifier that the policy author designates. The numbering system is entirely up to the contractor and is used to catalog the policy for internal use.
Description	A definition of the service and explanation of how it operates or is performed.
Policy Status	Indicate whether the policy is: (1) draft, or(2) final.
Benefit Category	The benefit category this service applies to (see §1861(s) of the Act.) For example: DME, Diagnostic Services, Prosthetic Devices and Laboratory. A full list of benefit categories is included in Exhibit ___.
HCPCS Codes	Enter the related HCPCS codes for the service. List each code and the actual HCPCS description. A policy may be associated with one or many HCPCS codes, one or many ranges of HCPCS codes, or a combination of all of these.
Revenue Codes	Intermediaries list applicable revenue codes.
HCFA's National Policy	Reference national coverage coding or policy, as appropriate.
Indications and Limitations of	List the general indications for which a service is covered. Also list limitations such as least costly alternative reductions.

Coverage and/or  
Medical Necessity

Utilization Guidelines	List the typical usage of the service and the corresponding narrative.
ICD-9 Codes and Narrative that Support Reasonable and Necessary	List the ICD-9 codes or code ranges, using maximum specificity, for which the service is generally covered. Can be associated with one or many diagnosis codes, one or many ranges of diagnosis codes, or a combination of all of these.
Reasons for Denial	The specific situations under which a service will <b>always</b> be denied. Also, list the reasons for denial such as "investigational, cosmetic, routine screening, dental, program exclusion, otherwise not covered, or never reasonable and necessary."
Noncovered ICD- 9 Code(s) and Narrative	If an item/service is <b>always</b> denied for a certain ICD-9 Code, list the ICD-9 Code(s) or Code range(s) and narrative that are <b>never</b> covered. A policy can be associated with one or many noncovered diagnosis codes, one or many ranges of diagnosis codes or a combination of all of these.
Sources of Information	List information sources and pertinent references (other than national policy) used in the development of this policy. Cite, for example, Agency for Health Care Policy and Research (AHCPR) guidelines, position papers released by specialty societies, or other sources used during the development of this policy. CMDs must also explain the rationale for their conclusions based upon references identified.
Coding Guidelines	Describe the relationships between codes and define how items/services are billable. Include information about the units of service, place of service, HCPCS modifiers, etc. Examples of appropriate coding techniques are: "use CPT code xxxxx to bill this item/service rather than yyyyy." Include payment issues and payment considerations in the Indications and Limitations of Coverage section.
Documentation Requirements	Specific information from the medical records or other pertinent information that would be required to justify the item/service. The Paperwork Reduction Act does not permit the request of additional documentation from a class of providers. (See 3.2.9) For example, progress notes, pathology report, certificate of medical necessity (CMN), or photographs. Give instructions as to how Electronic Media Claims billers should submit documentation.
Other Comments	Include information not included in other field sections. No maximum field length.

- Advisory Notes      Contractors **may** include important information regarding the policy which developed from advisory notes. For example, include the meeting date of advisory committees which the policy was discussed, any comments on the policy, any subcommittees formed to work on the policy, etc.
  
- Start Date of Comment Period      Enter the date the LMRP was released for comment. Use MM/DD/YY as the format. When no day is provided, enter 01 as the day.
  
- Start Date of Notice Period      Enter the date the medical community was notified about the LMRP. Use MM/DD/YY as the format. When no day is provided, enter 01 as the day.
  
- Effective Date      List the medical policy effective date. For example, all policy rules, requirements, and limitations become effective in the claims processing system as of this date. For contractors other than DMERCs, this occurs 30 days after the start of the Notice period. For DMERCs, this occurs 45 days after the start of the Notice period. Use MM/DD/YY as the format. When no day is provided, enter 01 as the day (required for DMERCs).
  
- Revision Date      Enter the date the LMRP is revised. If the policy is new, this field is empty. As the policy is revised, all revision dates are listed with the most recent revision date listed first. Use MM/DD/YY as the format.
  
- Revision Number      This is a unique identifier the contractor designates. This allows users to recognize if a policy is changed from its original form. The numbering system is entirely up to the contractor and is used to catalog the policy for internal contractor use.

All LMRPs must include the following paragraph:

"This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which includes representatives from [fill in appropriate specialty name]."

## **Exhibit 7 - Sample Letter for On-Site SVRS Reviews{tc \11 "7 B Sample Letter for On-Site SVRS Reviews}**

DATE:

PROVIDER NAME:

CONTRACTOR NAME:

PROVIDER ADDRESS:

CONTRACTOR ADDRESS:

PROVIDER NUMBER:

OPENING

Dear \_\_\_\_\_:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on \_\_\_\_\_. Based on this review we have determined that you have been overpaid. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that your facility utilized \_\_\_\_\_ services at a rate of 50 percent more than that of your peer group.

HOW THE OVERPAYMENT WAS DETERMINED

A random sample of \_\_\_\_\_ claims processed from 01/01/98 to 06/30/98 was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Our review found that some services you submitted were not reasonable and necessary as required by the Medicare statute or did not meet other Medicare coverage requirements.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable or necessary, and/or you did not follow correct procedures or use care in billing or receiving payment.

The attachment identifies the specific claims that have been determined to be fully or partially non-covered, the specific reasons for denial, an explanation of why you are responsible for the incorrect payment and the amount of the overpayment.

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by \_\_\_\_\_ and no interest charge will be assessed. Make the check payable to Medicare Part A and send it with a copy of this letter to:

Intermediary's Address

IF YOU DO NOT REFUND WITHIN 30 DAYS:

If you repay the overpayment within 30 days, you will not have to pay any interest charge.

However, if you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of \_\_\_\_\_ percent for each 30-day period. Periods of less than 30 days will be counted as 30-day periods.

On \_\_\_\_\_ we will automatically begin to offset the overpayment amount against your pending claims. Offset payments will be applied to the accrued interest first and then to the principal. If you believe that offset should not be put into effect, submit a statement within 15 days of the date of this letter to the above address, giving the reason(s) why you feel this action should not be taken.

For copies of the applicable laws and regulations, please contact us at the address shown in our letterhead, to the attention of the \_\_\_\_\_ Department.

**APPEAL RIGHTS:**

For Part A services, you may appeal denials for which you are determined to be liable under §1879 of the Act, or for which the beneficiary is determined to be liable but refuses to exercise his/her appeal rights. If you disagree with these determinations, you must request a reconsideration within 60 days of the date of this letter. Refer to the appeals procedure in your Provider Manual Section \_\_\_\_\_.

**GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN**

This review has shown that you are not following national Medicare guidelines in submitting claims for necessary and reasonable \_\_\_\_\_ services. In addition, you have not followed the Provider Bulletins and letters sent to you regarding local medical review policies and specific problems that we have identified with your billing practices. Your future claims for \_\_\_\_\_ will be suspended for prepayment review until you correct your billing.

If you have any questions regarding this matter, please contact \_\_\_\_\_ at \_\_\_\_\_. Thank you in advance for your prompt attention to this matter.

Sincerely,

**7.1 - Attachment to Letter for Provider Site SVRS Reviews{tc \12 "7.1 B Attachment to Letter for Provider Site SVRS Reviews}**

Following is a list of the claims denied as a result of the review:

- Beneficiary Name: John Smith
- HI Claim Number: 000-00-0000 A
- Service Dates: 12/08/97 - 12/08/97
- Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/97
- Reason for Denial: MRI's are not considered reasonable and medically necessary for the diagnosis of xxxx.
- Why the Provider is Responsible: We believe you knew or should have known that the services were not reasonable and necessary because you were notified in a Provider

Bulletin. The Bulletin dated April 1, 1997, outlined Local Medical Review Policy which indicated that MRI's were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.

- Overpayment: \$900.00
- Beneficiary Name: Mary Smith
- HI Claim Number: 000-00-0000 B
- Service Dates: 10/01/97 - 10/31/97
- Services Denied and Dates: Physical therapy evaluation and re-evaluation on 10/03/97 and 10/26/97.
- Reason for Denial: The two physical therapy visits are not reasonable and medically necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation.
- Why you are Responsible: In a letter dated 07/30/97 you were notified that such therapy evaluation and re-evaluation were not considered reasonable and necessary. Therefore, you are responsible for the overpayment.
- Overpayment: \$ 200.00
- Beneficiary Name: Tom Jones
- HI Claim Number: 000-00-0000 A
- Service Dates: 12/10/97 - 12/31/97
- Services Denied and Dates: 10 physical therapy visits from 12/10/97 - 12/31/97
- Reason for Denial: No plan of care signed by a physician.
- Why you are responsible: We find you responsible for the overpayment because regulations at 42 CFR, and manual instructions at §xxxx, clearly require a plan of care signed by a physician for therapy visits.
- Overpayment: \$1,200.00

## **7.2 - Intermediary SVRS Review Procedures Using Statistical Sampling for Overpayment Estimation (Type 2)**

These guidelines explain SVRS reviews using statistical sampling to calculate and project overpayments. They provide the minimal elements necessary in a sample design to ensure that proper statistical techniques and controls are used. They provide a minimum acceptable standard

that may be elaborated by the use of professional sampling expertise and/or the resources listed below.

H. Arkin, *Handbook of Sampling for Auditing and Accounting* (Englewood Cliffs: Prentice-Hall, 3d ed. 1984).

William Gemmell Cochran, *Sampling Techniques*, (New York: John Wiley and Sons, 3d ed. 1977).

S. B. Cohen, *An Evaluation of Alternative PC-Based Software Packages Developed for the Analysis of Complex Survey Data*, *The American Statistician* 51, at 285-92 (1997).

William Edwards Deming, *Sample Design for Business Research* (New York: John Wiley & Sons, 1960).

Morris H. Hansen, et al., *Sample Methods and Theory* (New York: John Wiley and Sons, vol. 1, 1953).

Leslie Kish, *Survey Sampling* (New York: John Wiley and Sons, 1965).

B. Ostle, and R.W. Mensing, *Statistics in Research* (Ames: The State UP, 3d ed. 1975).

George W. Snedecor and William Gemmell Cochran, *Statistical Methods* (Ames: Iowa State UP, 8th ed. 1989).

Alan Stuart, *The Ideas of Sampling* (New York: MacMillan, 1984).

In addition to the resources listed here, the contractor may also contact the local Chapter of the American Statistical Association or local universities to request names of statisticians who may help them on a consulting basis. The RO may also have additional references and resources.

## **A - Use of SVRS Sampling Procedures**

The contractor must employ statistical sampling techniques to estimate overpayments to providers for services that do not meet coverage or coding requirements, including the requirements. SVRS sampling must be used to assess and project these provider overpayments for recovery. HCFA Ruling 86-1 explains HCFA's authority to use statistical sampling to estimate overpayments to providers.

These SVRS procedures (§5.3) are not intended to cover all situations in which HCFA may authorize the use of statistical sampling and overpayment estimation methodologies. In addition, the specific sampling procedures and limits on the use of sampling and overpayment estimation methodologies in this instruction may not be appropriate for all situations in which HCFA uses or decides to use sampling and overpayment estimation methodologies.

These procedures can be applied to provider billings for which contractors have medical review responsibility, e.g., hospital outpatient, SNF, hospice, HHA, CORF, rehabilitation facilities, physicians, labs, DME suppliers, etc.

## **B - Conducting An SVRS**

The major steps in a statistically valid random sampling are:

- Selecting providers;
- Selecting the period to be reviewed;
- Defining the universe and the sampling frame;
- Designing and selecting the sample;
- Adjudicating the sample;
- Calculating the estimates;
- Notifying the appropriate persons of the CMR results; and
- Referring results to the Audit/Reimbursement unit for recovery of the overpayment.

Methods for completing these steps are presented in detail in the following sections.

### **C - When Sampling Is Appropriate**

HCFA and its Medicare contractors may use statistical sampling to project overpayments to providers and suppliers when claims volume is high and reflects a pattern of erroneous billing or overutilization, and when a case by case review is not administratively feasible. (See HCFA Ruling 86-1.) While intermediaries retain the discretion to conduct statistical sampling when appropriate, the use of this procedure as a method of calculating overpayments is generally limited to the situations described in PIM Chapter 3, §5.3 above.

In general, intermediaries evaluate each case on factors including, but not limited to:

- The number of claims in the universe and the dollar values associated with those claims;
- The degree to which the provider meets the provider selection criteria in PIM Chapter 3, §5.1.1;
- The intermediary resources available; and
- The cost effectiveness of the expected sampling results.

### **D - Consultation With a Statistical Expert**

Before undertaking a review that uses statistical sampling methods, intermediaries must consult with a statistician or other person with expertise in statistical sampling and extrapolation methods to review and approve proposed statistical sampling methods to be used in the review. The statistician must submit to the intermediary a written approval of the methodology for the type of study to be performed. At a minimum, the individual consulted should possess a

master's degree in statistics or equivalent in experience with statistical sampling methods at the level of Cochran's well-known textbook, or those of Kish or Deming. If an intermediary does not have staff who have previously conducted statistical studies, they must obtain expert assistance prior to conducting a review that uses statistical sampling methods. (See PIM Chapter 3 §5.3 above.)

## **7.3 - Select SVRS Period To Be Reviewed and Composition of Universe**

### **A - Selection of Period for Review**

Once MR has selected a provider for the SVRS review, they determine the period to be reviewed. They will select their universe from this period. **However, all claims reviewed must be drawn from within a provider's defined cost-reporting year.** The period for review should be selected as follows:

- Select the most recently processed claims for periods from 4 months up to 1 year. Consider:
  - How long the problem has existed and in what volume;
  - How long the associated national or local MR policy has been in effect;
  - The extent of prepayment review already conducted; and
  - The availability of medical documentation.
- If there is evidence of fraud, intermediaries may select the most recently processed claims for periods up to 3 years. **However, to ensure that overpayment adjustments can be accurately reflected on a provider's cost report, it is important that the time period from which any sample of claims is drawn is contained within a defined cost-reporting year.** Therefore, if intermediaries are looking at a period greater than one year, they must select a separate sample for each cost-reporting year.

### **B - Composition of Universe**

The intermediary universe and sampling frame for the review will be all claims from the period under review or claims for that period that contain the specific services they have identified for study. The universe of claims from which the sample is chosen consists of adjudicated claims (both denied and paid claims) obtained from the shared systems. Services identified for study will depend upon the type of provider being reviewed (see PIM Chapter 3, §§5.3.7, 5.3.8, 5.3.9, 5.3.10) and the problem area(s) MR has identified through their data analysis. For example, if they are reviewing home health agency XYZ for the period January - June 1997, and their analysis indicates that they should focus on home health aide visits billed by Agency XYZ, their universe from which they select their sample will be all claims from January - June 1997 that contain home health aide services billed by Agency XYZ.

In another instance, MR may be reviewing Agency ABC for the period January - December 1997 because of problems with lack of homebound status. Denials made on this basis will likely result

in a denial of the entire claim. In this case, their universe will be all home health claims billed by Agency ABC for the period January - December 1997. However, because overpayments that are projected and recovered must ultimately be reflected on a provider's cost report, their projection methodology must be based on the individual disciplines contained on each claim. (See PIM Chapter 3 §§5.3.2 , 5.3.7, 5.3.8, 5.3.9, 5.3.10 for a detailed explanation.)

## **7.4 - Select Sample**

MR must send informational copies of the statistician-approved sampling methodology to the RO prior to selecting their sample. The RO will forward the methodology to CO.

### **7.4.1 - Select Sample Design**

Intermediaries must identify their sampling design. The most common designs used are simple random sampling, stratified sampling, and multistage sampling, or a combination of these. The sampling design should be documented in full detail. Sample size is discussed more thoroughly below. However, the design for reviews should consider the benefit-to-cost ratio. The confidence interval will be computed after the review has been done, and **the lower bound** used to determine the overpayment amount. In general, the 90 percent confidence level will be used. As MR gains experience in applying sampling techniques to the claims process audit, they will develop a better idea of the level of precision of estimation associated with various sample sizes.

#### **A - Random Number Selection**

Medical Review must identify the source of the random numbers used to select sample items. A recommended source of random numbers is RAT-STATS, although any reputable random number selection method may be used. RAT-STATS is a software application program that assists the user in selecting random samples and evaluating the results. The software is designed to operate on personal computers using Microsoft Disk Operating System (MS-DOS). The RAT-STATS software program was developed by the Department of Health and Human Services, Office of the Inspector General, Office of Audit Services, Regional Advanced Techniques.

RAT-STATS can develop a confidence level at 90 or 95 percent. The 90 percent confidence generally will be used. In addition to generating random numbers and estimating sample sizes, RAT-STATS computes proportions, means, and confidence limits for various sample designs.

Refer to the RAT-STATS User Manual for more detailed instructions on the software program. The software package can be obtained through the Department of Health and Human Services, Office of the Inspector General Web Site. It may be accessed as follows:

<http://www.hhs.gov/progorg/oas/pubs.html>

### **7.4.2 - Select Sample Size and Claims to Include**

For simple random sampling, the recommended minimum sample size is 100 sampling units. Use of larger sample sizes usually has the advantage of yielding estimates with better estimated precision. Better precision results in a larger lower bound for the confidence interval of the estimate. Experience will determine the necessity for larger sample sizes.

For stratified random sampling, the recommended minimum sample size is 100 sampling units with a minimum of 30 sampling units per stratum. If fewer than 30 are present, then all units are used. There are various methods for allocating sample items among the strata including proportional allocation and optimal allocation. The sample sizes for the strata do not have to be identical or multiples of each other.

For multistage sampling, at least 8 primary sample units must be selected with a sample of at least 30 transactions for each primary sample unit.

Variances and coefficients of variation (CVs) needed to guide more refined estimates of sample size may be drawn from experience such as:

- Previous overpayment samples (e.g., sample reviewed to confirm existence of a problem); or
- Prepayment reviews resulting in payment denials. These can be used to determine the potential correct payment amount and the CV of the potential overpayment.

## **A - Claims to Be Included in the Sample**

Intermediaries include paid and MR denied claims in their sample to ensure a provider the full opportunity for an underpayment projection as well as an overpayment projection. They exclude the following claims from the sample:

- A request for reconsideration was filed timely for Part A claims (see 42 CFR 405.710ff);
- A request for review was filed timely for Part B claims. (see 42 CFR 405.807ff); and
- Demand bills and services that were included in the universe for a time period previously sampled.

Ensure that your sample is large enough to account for the deletion of claims referenced above, and those claims which may be excluded based on your liability analyses as described in PIM Chapter 3, §5.3.3.4.

## **B - Relationship of Sampling Units to Provider Cost Reports**

Unlike procedures for physicians and suppliers, overpayment projection and recovery procedures for providers and non-physician practitioners who bill intermediaries must be designed so that overpayment amounts can be accurately reflected on the provider's cost report. Therefore, sampling observation units must coincide with a projection methodology designed specifically for that type of provider to ensure that the results can be placed at the appropriate points on the provider's cost report.

The sample may be either claim-based or composed of specific line items. For example, home health cost reports are determined in units of "visits" for disciplines 1 through 6 and "lower of costs or charges" for drugs, supplies, etc. (See PIM Chapter 3, §5.3.7, note that the Balanced

Budget Act of 1997 (BBA) changes the manner in which many providers' cost reports are settled.) Therefore, if MR is performing a review using statistical sampling for a home health agency and are reviewing services that fall under disciplines 1 through 6, the projection methodology used for this home health provider must be based on visits, thereby requiring them to use visits as their observation unit.

If an entire home health claim is denied because of lack of homebound status, the claim must still be broken down to the number of visits denied for disciplines 1 through 6, and the lower of costs or charges for drugs, supplies, etc., for sampling and overpayment projection purposes.

In summary, because the projection methodology used for a particular provider type and the ultimate settlement of the provider's cost report require that services be separated first as Part A and Part B services and then by discipline within Part A or Part B, the sample must ultimately be broken down to this level of detail. (The results of a sample are extrapolated only to the universe from which the sample was drawn. For example, if the sample consists only of claims with home health aide visits, then the sample results are extrapolated only to the universe of claims with home health aide visits.)

Because of this cost report relationship, it is extremely important that **prior to selecting the sample**, MR must know what services they will be reviewing and how those observation units link to the provider's cost report. It is also extremely important that, regardless of how they select their sample, they use the projection methodologies provided in PIM Chapter 3, §§5.3.7, 5.3.8, 5.3.9, 5.3.10, of these instructions to determine the overpayment for the specific type of provider being reviewed. These instructions were developed to ensure a measure of consistency in the CMR process and to ensure that the overpayments can be accurately reflected on cost reports.

### **7.4.3 - Document Universe and Frame**

Sufficient documentation should be retained so that the sampling frame can be re-created, should the methodology be challenged. Explicit written statements must be included in the documentation as follows:

- How the universe is defined;
- Elements included;
- The nature of the frame;
- Specific designations as to the period covered;
- Identifiers for the sampling units such as claim numbers, intermediary control numbers, and dates of service and source;
- The random numbers actually used in the sample; and
- How the random numbers were selected.

## **A - Arrangement and Control Totals**

It is often convenient in frame preparation to array the universe elements by payment amount, e.g., low to high values, especially when stratification is used. At the same time, tabulate control totals for the numbers of elements and payment amounts. Submitted charges may also be tabulated for record comparison purposes.

## **B - Controls and Worksheets**

Control of the re-adjudication process and possible subsequent negotiations with the provider require appropriate worksheets. Each worksheet must contain at a minimum the following items of information:

- Name and number of provider;
- Any data extraction from the claim should include the Health Insurance Claim Number (HICN) and unique claim identifier (e.g. claim control number);
- Identification of each sampling unit and its components (e.g., UB92, attached medical information);
- Stratum and cluster identifiers, if applicable;
- The amount of the original submitted charges (in column form); and
- Any other information required by the cost report worksheets in PIM Chapter 3, §§5.3.7, 5.3.8, 5.3.9, and 5.3.10.

### **7.4.4 - Actions After Provider and Sample Have Been Selected**

#### **7.4.4.1 - File Compilation and Provider Notification of the Review**

After MR has selected a provider and the sample to be reviewed, they gather the history files and claims for the selected sample. They include all contractor claims or services information involved and they establish an audit trail that identifies the claims, services, or beneficiaries in question. They decide whether the CMR will be conducted in-house or onsite, request all necessary medical records for the period under review, and notify the provider of the impending review. (See PIM Chapter 3, §5.3.3.1A below for a sample letter.)

### **7.5 - Exhibit-Sample Letter--Request For Medical Records**

The intermediary uses the following letter to request necessary medical records from the provider.

**DATE:**

**PROVIDER NAME:**  
**PROVIDER ADDRESS:**  
**PROVIDER NUMBER:**

**INTERMEDIARY NAME:**  
**INTERMEDIARY ADDRESS:**

**OPENING:**

Dear XXXXX:

You have been selected for a comprehensive medical review (CMR) of your billing for Medicare services pursuant to HCFA's statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that you may be billing inappropriately for services.

We have selected a random sample of \_\_\_ claims for services provided during the period \_\_\_\_\_ through \_\_\_\_\_. (See attached listing.) For each of these claims, we are requesting the following information:

[The following list is for illustrative purposes. MR should request any documentation that will permit them to conduct a thorough review of the claims submitted with regard to coverage, eligibility, medical reasonableness and necessity, limitation on liability determinations (§1879), without fault determinations (§1870), etc.]

- Form HCFA-485;
- Form HCFA-486, or equivalent information, if applicable;
- Form HCFA-487, or equivalent information, if applicable;
- Flow sheets or treatment sheets, if used;
- Narrative or progress notes, if used;
- Supplemental order, if applicable;
- Itemized breakdown of supplies, if supplies are billed;
- Lab values, if applicable;
- Copy of the UB-92 for each bill;
- Lab reports for any B12 injections;
- Lab or x-ray reports for any calcimar injection;
- Other \_\_\_\_\_

The above information should be mailed to the following address within 30 days from the date of this letter:

Intermediary Name, Address, and Contact Person

Our medical review staff will review the documentation you submit for each of the claims to determine if the services billed are reasonable and necessary and meet all other requirements for Medicare coverage. Along with our claims payment determination, we will make a limitation on liability decision for services that are subject to the provisions of §1879 of the Social Security Act (the Act), and a determination in accordance with §1870 of the Act (whether you are without fault for any overpayments).

We will project the overpayments identified in the sample to the universe of claims processed during the time frame described above. We will adjust the projected overpayment to reflect any previously denied claims which are payable, denied claims for which you were found not liable under §1879 of the Act, and denied claims for which you were found to be without fault under §1870 of the Act.

Following our review, we will inform you in writing of our findings. We will provide you with a listing of the claims that were reviewed and our determinations with regard to those claims (i.e., full or partial denials and payable claims), the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, our liability determination for those denials that fall under §1879 of the Act, our determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, the amount of the overpayment or underpayment, and interest accrual on unpaid balances. We will provide you with an explanation of your right to submit a rebuttal statement under 42 CFR 405.370-375 if we determine that you have been overpaid, and your options for repaying any overpayments, or our refund of any underpayments. We will provide you with an explanation of how any overpayment was determined, including the sampling methodology used to project the amount of the overpayment. We will also provide you with a full explanation of your appeal rights, including appeal of the sampling methodology used to determine the overpayment, estimation of the overpayment, coverage decisions, limitation on liability decisions under §1879 of the Act, and our determination as to whether you are without fault under §1870 of the Act.

If you have any questions concerning this request, you may contact me at (telephone number). Your cooperation is appreciated.

Sincerely,

Enclosure: Listing of Sample Claims Requiring Medical Documentation

**7.6 - Exhibit: Part A Sample Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments**{tc \l2 "7.6 B Exhibit: Part A Sample Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments}

SAMPLE LETTER--MEDICARE PART A

**DATE:**

**PROVIDER NAME:**

**INTERMEDIARY NAME:**

**PROVIDER ADDRESS:**

**INTERMEDIARY ADDRESS:**

**PROVIDER NUMBER:**

**OPENING**

DearXXXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on \_\_\_\_\_. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.750 and have determined that you have been overpaid in the amount of \_\_\_\_\_. We hope the following information answers any questions you may have.

**REASON FOR REVIEW**

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

**HOW THE OVERPAYMENT WAS DETERMINED**

A randomly selected sample of \_\_\_\_\_ claims processed from \_\_\_\_\_ to \_\_\_\_\_ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

**TOTAL OVERPAYMENTS**

(List the aggregate overpayments)

Be advised that this overpayment amount is based on your interim payment rate in effect at the time the review was done. Further adjustments may be made when your cost report is settled.

## **GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN**

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable \_\_\_\_\_ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for \_\_\_\_\_ may be subject to prepayment review until you correct your billing.

## **WHY YOU ARE RESPONSIBLE**

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of the specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclose a list of the specific claims from the sample that have been found not to be covered. See the example within this exhibit.)

The sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclosed an explanation of the sampling methodology.)

## **WHAT YOU SHOULD DO**

Please return the amount of the overpayment to us by (insert date, 15 days from date of letter). However, you may request an extended repayment schedule in accordance with 42 CFR 401.607(c). Please contact (name of contact person at the FI/RHHI) on (phone number of contact person) to discuss repayment options for the full amount of the overpayment determined by the projection of errors found on the \_\_\_ claim sample.

## **INTEREST**

If you refund the overpayment within 30 days, you will not have to pay any interest charge. If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of \_\_\_\_\_ percent for each 30-day period. Periods of less than 30 days will be counted as 30-day periods. Medicare charges interest on its outstanding Part A debts in accordance with §1815(d) of the Act and 42 CFR 405.378.

## **RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT**

As provided in regulations at 42 CFR 401.607(a) and 405.370-375, on (insert date provided in above paragraph captioned, "What You Should Do"), we will automatically begin to recoup the overpayment amount against your pending and future claims. If you do not repay the debt within 30 days, we will apply your payments, and amounts we recoup, first to accrued interest and then

to principal. Also, in accordance with the Debt Collection Improvement Act, we may refer your debt to the Department of Treasury for offset against any monies payable to you by the federal government.

You have the right to submit a rebuttal statement in writing within fifteen days from the date of this letter. Your rebuttal statement should address why the recoupment should not be put into effect on the date specified above. You may include with this statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal statement and evidence should be sent to:

FI Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal statement and any supporting evidence, we will consider and determine within fifteen days whether the facts justify continuation, modification, or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date stated in this notice while we review your rebuttal statement. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; or (3) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

If you choose not to submit a rebuttal statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, "What You Should Do"). Whether or not you submit a rebuttal statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal statement are not initial determinations as defined in 42 CFR 405.704, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

## **YOUR RIGHT TO CHALLENGE OUR DECISIONS**

This letter serves as our revised determination of the claims listed in the Attachment. If you disagree with this determination, you must request a reconsideration within 60 days of the date you receive this letter (receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations under Part A and overpayment recovery. (See 42 CFR 405.701, et seq.) You may ask for a review of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual § \_\_\_\_\_ for further details.)

If you have any questions regarding this matter, please contact \_\_\_\_\_ at \_\_\_\_\_.  
(Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

**7.6.1 - Exhibit: Attachment to the Part A Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments}**  
**7.6.1 B Exhibit: Attachment to the Part A Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments}**

The following is a list of claims denied as a result of the review:

**A. Beneficiary Name: John Smith**

1. HI Claim Number: 000-00-0000 A
2. Service Dates: 12/01/96 - 01/15/97
3. Services Denied and Dates: 45 Inpatient SNF Days, 12/1/96 - 1/15/97
4. Reason for Denial: The therapy services rendered were not medically reasonable and necessary because they were for overall fitness and general well being and did not require the skills of a qualified physical therapist (§1879 denial). (Provide details that led you to the conclusion that the services were non-skilled.)
5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. We believe you knew or should have known that the services were not medically reasonable and necessary because of the educational contacts made in July 1996 and October 1996 regarding Medicare coverage of therapy services. In these contacts numerous similar examples were cited as noncovered. Therefore, you are responsible for paying the overpayment amount.
6. Overpayment: \$2,000.00

**B. Beneficiary Name: Mary Smith**

1. HI Claim Number: 000-00-0000 B
2. Service Dates: 01/01/97 - 01/31/97
3. Services Denied and Dates: 31 Inpatient SNF Days, 01/01/97 - 01/31/97
4. Reason for Denial: There was no skilled care furnished on a daily basis. Skilled therapy services were furnished 2-3 times a week, although therapy is available in your facility on a daily basis.
5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. The Medicare

coverage guidelines in the SNF manual clearly state the requirement for daily skilled services. You were also notified in educational contacts in July 1997 and October 1997 of similar cases. Therefore, you are responsible for the overpayment.

6. Overpayment: \$200.00

## **7.7 - Exhibit: Part B Sample Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments**

SAMPLE LETTER--MEDICARE PART B

**DATE:**

**PROVIDER NAME:**

**INTERMEDIARY NAME:**

**PROVIDER ADDRESS:**

**INTERMEDIARY ADDRESS:**

**PROVIDER NUMBER:**

### **OPENING**

Dear XXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on \_\_\_\_\_. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.841 and have determined that you have been overpaid in the amount of \_\_\_\_\_. We hope the following information answers any questions you may have.

### **REASON FOR REVIEW**

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

### **HOW THE OVERPAYMENT WAS DETERMINED**

A randomly selected sample of \_\_\_\_\_ claims processed from \_\_\_\_\_ to \_\_\_\_\_ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been

included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

## **TOTAL OVERPAYMENTS**

(List the aggregate overpayments)

Be advised that this overpayment amount is based on your interim payment rate in effect at the time the review was done. Further adjustments may be made when your cost report is settled.

## **GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN**

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable \_\_\_\_\_ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for \_\_\_\_\_ may be subject to prepayment review until you correct your billing.

## **WHY YOU ARE RESPONSIBLE**

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclosed a list of the specific claims and an explanation of fault for each. See the example within this exhibit.)

An explanation of the sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclose an explanation of the sampling methodology.)

## **WHAT YOU SHOULD DO**

Please return the amount of the overpayment to us by (insert date, 15 days from date of letter). However, you may request an extended repayment schedule in accordance with 42 CFR 401.607(c). Please contact (name of contact person at the FI/RHHI) on (phone number of contact person) to discuss repayment options for the full amount of the overpayment determined by the projection of errors found on the \_\_\_ claim sample.

## **INTEREST**

If you refund the overpayment within 30 days, you will not have to pay any interest charge. If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of \_\_\_\_\_ percent for each 30-day period. Periods of less than 30 days will be counted as 30-

day periods. Medicare charges interest on its outstanding Part B debts in accordance with §1833(j) of the Act and 42 CFR 405.378.

## **RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT**

As provided in regulations at 42 CFR 401.607(a) and 405.370-375, on (insert date provided in above paragraph captioned, “What You Should Do”), we will automatically begin to recover the overpayment amount against your pending and future claims. If you do not repay the debt within 30 days, we will apply your payments, and amounts we recoup, first to accrued interest and then to principal. Also, in accordance with the Debt Collection Improvement Act, we may refer your debt to the Department of Treasury for offset against any monies payable to you by the federal government.

You have the right to submit a rebuttal statement in writing within fifteen days from the date of this letter. Your rebuttal statement should address why the recoupment should not be put into effect on the date specified above. You may include with this statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal statement and evidence should be sent to:

FI Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal statement and any supporting evidence, we will consider and determine within 15 days whether the facts justify continuation, modification or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date stated in this notice while we review your rebuttal statement. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; or (3) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

If you choose not to submit a rebuttal statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, “What You Should Do”). Whether or not you submit a rebuttal statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal statement are not initial determinations as defined in 42 CFR 405.803, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

## **YOUR RIGHT TO CHALLENGE OUR DECISIONS**

This letter serves as our revised determination of the claims listed in the attachment. If you disagree with this determination, you must request a review (**if the amount in controversy is \$100 or less, or a Hearing Officer hearing if the amount in controversy is greater than \$100**) within 6 months of the date of this letter. You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations of Part B services billed to the Fiscal Intermediary, and overpayment recovery. (See 42 CFR 405.801, et seq. and 42 CFR 405.701, et seq.) You may ask for a review of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may

also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual Section \_\_\_\_\_ for further details.)

If you have any questions regarding this matter, please contact \_\_\_\_\_ at \_\_\_\_\_.  
(Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

**7.7.1 - Exhibit: Attachment to the Part B Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments**  
**7.7.1 B Exhibit: Attachment to the Part B Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments**

The following is a list of the claims denied as a result of the review:

**A. Beneficiary Name: John Smith**

1. HI Claim Number: 000-00-0000 A
2. Service Dates: 12/08/96 - 12/08/96
3. Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/96
4. Reason for Denial: MRIs are not considered medically reasonable and necessary for the diagnosis of xxxx (§1879 denial).
5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. You knew or should have known that the services were not medically reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1996, outlined Local Medical Review Policy which indicated that MRIs were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.
6. Overpayment: \$900.00

**B. Beneficiary Name: Mary Smith**

1. HI Claim Number: 000-00-0000 B
2. Service Dates: 01/01/97 - 01/31/97
3. Services Denied and Dates: Physical Therapy evaluation and re-evaluation on 01/03/97 and 01/26/97

4. Reason for Denial: The two Physical Therapy visits are not medically reasonable and necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation (§1879 denial).
5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. In a letter dated 10/30/96, you were notified that such therapy evaluation and re-evaluation were not considered medically reasonable and necessary. Therefore, you are responsible for the overpayment.
6. Overpayment: \$200.00

## **Exhibit 8 - Recovery of Overpayment and Corrective Actions {tc \l1 "8 B Recovery of Overpayment and Corrective Actions }**

After MR issues revised determinations that notify the provider of the CMR results, their intention to recoup or offset payment and the provider's right to submit a rebuttal statement (see PIM Chapter 3, §§5.3.3.6 and 5.3.3.6A and 5.3.3.6C), the Audit/Reimbursement (A/R) staff may begin recovery of the lower bound of the estimated total overpayment on the 15th day from the date of the notification letter to the provider. (See also MIM §§2220 - 2229, MIM §§3707 - 3711, PIM Chapter 3, §5.3.2 and PIM Chapter 3 §6.6.)

Prior to recoupment of overpayments, providers and suppliers have a right to submit a rebuttal statement in accordance with 42 CFR 405.370-375. The rebuttal statement and any accompanying evidence must be submitted within 15 days from the date of the CMR notification letter described in PIM Chapter 3, §5.3.3.6 unless MR or Audit/reimbursement staff find cause otherwise to extend or shorten the time afforded for submission of the statement. The provider's rebuttal statement should address why the recovery should not be put into effect on the date specified in the notification letter. MR and AR staff should consider all of the evidence timely submitted to reach a determination regarding whether the recoupment should be delayed. However, recovery of any overpayment will not be delayed beyond the date indicated in the CMR notification letter in order to review and respond to the rebuttal statement. (See 42 CFR 405.375(a).)

Substantive evidence that MR claims determinations were incorrect generally should not be considered during the rebuttal process unless such evidence relates to the timing of the recoupment of the overpayment. Substantive evidence on claims determinations is properly heard during a reconsideration under Part A or a review determination or HO hearing under Part B. However, in order to avoid unnecessary appeals, if it is clear from the evidence submitted that MR revised determination was in whole, or in part, incorrect, they may consider such evidence. If such evidence warrants changes to any claims determinations made during the reopening, they work with Audit/Reimbursement staff to recalculate the amount of the overpayment, and issue a modified revised determination in accordance with the procedures in PIM Chapter 3, §5.3.3.6.

Should MR issue a modified revised determination, they send notice of the results of the modification to any beneficiary whose claims have been affected. In addition, they notify the provider that the applicable time period for filing a request for reconsideration of Part A services or a review determination of Part B services begins on the date of the modified revised determination. **However, recovery of any overpayment, even if the principal of the debt is modified after reviewing the rebuttal statement, will not be delayed beyond the date indicated on the revised determination.** Furthermore, since the provider has previously had an opportunity to submit a rebuttal statement, MR is not required to offer a provider an opportunity to submit a rebuttal statement in response to the modified revised determination. The provider may challenge the claims determinations and sampling methodology in the administrative appeals process.

Because of the cost report relationship to the overpayment, it is important to note that the projected overpayment recovered from a provider as a result of a CMR using statistical sampling is based on the interim payment rate in effect at the time of the CMR. A/R may make subsequent adjustments when the cost report is settled to reflect final settled costs.

## **Exhibit 9 - Projection Methodologies and Instructions for Reviews of Home Health Agencies**

### **A - Reimbursement Methods for Home Health Agencies (HHAs)**

Based on the findings from the statistically valid random sample, the Fiscal Intermediary (FI)/Regional Home Health Intermediary (RHHI) will project by discipline to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by discipline (e.g., skilled nursing, physical therapy) for a specified time frame within a single cost reporting period. They determine the reimbursement method for the service(s) reviewed as shown below to ascertain the appropriate projection methodology to be used.

HHAs are reimbursed as follows:

- Discipline: Patient Services--Reimbursed By Cost Per Visit
  - Skilled Nursing;
  - Physical Therapy;
  - Occupational Therapy;
  - Speech Pathology;
  - Medical Social Services; and
  - Home Health Aide Service
  
- Other Patient Services - Reimbursed By Lower of Costs or Charges

-Cost of Medical Supplies;

-Cost of Drugs

Please note that the reimbursement methodology for HHA's was changed by the BBA for cost report periods beginning on or after October 1, 1997.

## **B - Procedures for Disciplines 1 through 6, which are reimbursed by cost per visit:**

The following procedures apply to disciplines 1 through 6, which are reimbursed by cost per visit:

- The sample may be chosen from a frame including claims with a particular or many disciplines;
- For each discipline, MR determines the total number of visits and number of visits denied by re-adjudication;
- MR determines the ratio of denied Medicare visits to the total Medicare visits in the sample and the 90 confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of services to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total number of Medicare visits in the frame. This will determine the projected total number of visits to be denied for the period and the adjusted Medicare visits;
- If the adjustment occurs prior to the submission of the cost report, the projected denied visits will be multiplied by the provider's interim payment rate per visit to determine the overpayment amount by discipline subject to collection. The FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options;
- Upon submission of the cost report, total visits on the cost report will not change. The cost per visit computation will remain the same. Only the Medicare visits and the total cost of Medicare services will be reduced. The charges that are applicable to these adjusted costs must also be determined. Both of these adjusted totals are needed to settle the cost report. For cost report periods beginning prior to 10/1/97, HHA cost reports are settled on the lesser of reasonable cost or customary charges. Under the BBA, for cost report periods beginning on or after 10/1/97, the methodology for settling HHA cost reports has changed. Medical Review staff must complete worksheets 1-7 and notify Audit and Reimbursement staff of all necessary adjustments so that the amount can properly be reflected in the cost report.

Worksheets 1 through 7 may be accessed by clicking on the links below:

Worksheet 1: Home Health Agency (HHA) Calculation of Medical Review Audit Adjustment - Form HHA/Audit-1

Worksheet 2: Home Health Agency (HHA) Calculation of Charges Applicable to Adjusted/Denied Visits - Form HHA/Audit-2

Worksheet 3: Home Health Agency (HHA) Medical Review Sampling Results, Form HHA/MR-1, page 1

Worksheet 4: Home Health Agency (HHA) Medical Review Sampling Results, Form HHA/MR-1, page 2

Worksheet 5: Home Health Agency (HHA) Medical Review Sampling Results, Form HHA/MR-1, page 3

Worksheet 6: Home Health Agency (HHA) Summary of Results Medical Review Sampling - Form HHA/MR-2

Worksheet 7: Home Health Agency (HHA) Summary of Results Medical Review - Form HHA/MR-3

## **C - Procedures for Other Patient Services**

The following procedures apply to other patient services:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;

- If the adjustment occurs prior to the submission of the cost report, the FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, as in the case for disciplines 1 through 6, medical review staff must complete worksheets 1 - 7 identified in §5.3.7B above, and provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

## **D - Coordination Between Medical Review and Audit and Reimbursement Staff**

To preserve the integrity of Provider Statistical and Reimbursement Report (PS&R) data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with HHAs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections on denied HHA services must be made for each discipline and revenue center, as instructed above;
- When notifying the provider of the review results for cost reimbursed services, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost report settlement to reflect final settled costs;
- Information from the completed Worksheets 1 - 7 identified in §5.3.7B above, must be routed to the FI/RHHI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the number of denied services (actual denied services plus projected denied services) for each discipline and the amounts of denied charges (actual denied amounts plus projected denied amounts) for supplies and drugs; and
- Upon completion of the review, furnish the audit and reimbursement staff with the information listed in PIM Chapter 3 §5.3.1.

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered for cost based services based on the denied services, units and charges, and the provider's allowed costs;
- Use the information on denied services to ensure accurate settlement of the cost report and/or any adjustments to interim rates that may be necessary as a result of MR findings. Audit adjustments will be made to PS&R statistics on the cost report to

decrease Medicare visits, increase other visits (total visits remain unchanged) and to adjust Medicare charges, as necessary; and

- In the event that a cost report has been settled, determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

## **Exhibit 10 - Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs)**

### **10 B Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs)**

#### **A - Projecting From a Sample to a Universe on SNF Claims**

Based on the findings from the statistically valid random sample, the FI will project by ancillary cost center, to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

Ancillary Service Cost Centers reimbursed by Lower of Costs or Charges are:

- Radiology;
- Laboratory;
- IV Therapy;
- Oxygen Therapy;
- Physical Therapy;
- Occupational Therapy;
- Speech Pathology;
- Electrocardiology;
- Medical Supplies;
- Drugs Charged; and
- Other

**NOTE:** Effective July 1, 1998, SNF services will be reimbursed in accordance with the provisions in the BBA.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;

- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, Medical Review staff will complete Worksheets 8 - 17, and provide the Audit and Reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 8 through 17 may be viewed by double clicking on the name (link) below:

Worksheet 8: Skilled Nursing Facility (SNF) Calculation of Medical Review Audit Adjustment - Form SNF/Audit-1

Worksheet 9: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 1

Worksheet 10: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 2

Worksheet 11: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 3

Worksheet 12: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 4

Worksheet 13: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 5

Worksheet 14: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 6

Worksheet 15: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 7

Worksheet 16: Skilled Nursing Facility (SNF) Summary of Results of Medical Review Sampling - Form SNF/MR-2

Worksheet 17: Skilled Nursing Facility (SNF) Summary of Results of Medical Review - Form SNF/MR-3

## **B - Coordination Between Medical Review and Audit and Reimbursement Staff**

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with SNFs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied SNF services must be made by each individual ancillary cost center, as instructed above;
- Denied charges must be segregated between Part A and Part B as the SNF Medicare cost report is set up to apportion costs and make separate settlements for Part A and Part B;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 8 - 17 (PIM chapter 3, §5.3.8 above), must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and
- Upon completion of the review, MR furnishes the audit and reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and

- In the event that a cost report has been settled, they determine the impact and the actions to be taken. It is expected that, in most cases, cost reports will not have been settled or even filed.

## **Exhibit 11 - Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS)**

### **\11 "11 B Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS)**

#### **A - Projecting From a Sample to a Universe on CORF Claims**

Based on the findings from the statistically valid random sample, the FI will project by ancillary cost center to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by ancillary service for a specified time frame within a single cost reporting period. When making this determination, the following should be used:

- Ancillary Service Cost Centers that are reimbursed by reasonable costs are:
  - Skilled Nursing Care;
  - Physical Therapy;
  - Speech Pathology;
  - Occupational Therapy;
  - Respiratory Therapy;
  - Medical Social Services;
  - Psychological Services;
  - Prosthetic and Orthotic Devices;
  - Drugs and Biologicals;
  - Supplies Charged to Patients;
  - DME - Sold; and
  - DME - Rented.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;

- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the costs report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete Worksheets 24 - 30, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 24 through 30 may be viewed by double clicking on the name (link) below:

Worksheet 24: Comprehensive Outpatient Rehabilitation Facility (CORF) Calculation of Medical Review Audit Adjustment - Form CORF/Audit-1

Worksheet 25: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results- Form CORF/MR-1, page 1

Worksheet 26: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results- Form CORF/MR-1, page 2

Worksheet 27: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results- Form CORF/MR-1, page 3

Worksheet 28: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results- Form CORF/MR-1, page 4

Worksheet 29: Comprehensive Outpatient Rehabilitation Facility (CORF) Summary of Results of Medical Review Sampling - Form CORF/MR-2

Worksheet 30: Comprehensive Outpatient Rehabilitation Facility (CORF) Summary of Results of Medical Review - Form CORF/MR-3

## **B - Coordination Between Medical Review and Audit and Reimbursement Staff**

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CORFs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied CORF services must be made by each individual ancillary cost center, as instructed above;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 24 - 30 in PIM chapter 3, §5.3.9A, must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and
- Upon completion of the review, furnish the Audit and Reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

- Determine the actual cost report overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

## **Exhibit 12 - Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs)**

### **Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs)**

#### **A - Projecting From a Sample to a Universe on CMHC Claims**

Based on the findings from the statistically valid random sample, the FI will project by ancillary cost center to the universe from which the sample was drawn to derive an overpayment amount.

Determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

When making this determination, the following should be used:

Ancillary service cost centers that are reimbursed by lower of costs or charges are:

- Drugs and Biologicals;
- Occupational Therapy;
- Individualized Activity Therapy;
- Psychiatric/Psychological Service;
- Individual Therapy;
- Group Therapy;
- Family Counseling;
- Diagnostic Services; and
- Patient Training and Education.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges in the sample to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of services to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;

- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete worksheets 18 - 23, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 18 through 23 may be viewed by double clicking on the name (link) below:

Worksheet 18: Community Mental Health Clinic (CMHC) Calculation of Medical Review Audit Adjustment - Form CMHC/Audit-1

Worksheet 19: Community Mental Health Clinic (CMHC) Medical Review Sampling Results - Form CMHC/Audit-1, page 1

Worksheet 20: Community Mental Health Clinic (CMHC) Medical Review Sampling Results - Form CMHC/Audit-1, page 2

Worksheet 21: Community Mental Health Clinic (CMHC) Medical Review Sampling Results - Form CMHC/Audit-1, page 3

Worksheet 22: Community Mental Health Clinic (CMHC) Summary of Results of Medical Review Sampling - Form CMHC/MR-2

Worksheet 23: Community Mental Health Clinic (CMHC) Summary of Results of Medical Review - Form CMHC/MR-3

## **B - Coordination Between Medical Review and Audit and Reimbursement Staff**

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CMHCs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied CMHC services must be made by each individual ancillary cost center, as instructed above;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs; and

- Information from the completed worksheets 18 - 23 in PIM chapter 3, §5.3.10A must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts).

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

**Exhibit 13 - Postpayment CMR Summary Report Format**  
**Example {tc \11 "13 B Postpayment CMR Summary Report Format**  
**Example }**

Identification Section

Provider: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Address: \_\_\_\_\_ ID No. (SSN or EIN): \_\_\_\_\_

If Group, Number of Providers Involved: \_\_\_\_\_

(See attached for names and individual earnings)

Specialty: \_\_\_\_\_ Sub-Specialty: \_\_\_\_\_

Repeat Provider (Years): \_\_\_\_\_

**Payment and Utilization Data Section**

Payments: Year: \_\_\_\_\_ Assigned \$ \_\_\_\_\_ Unassigned \$ \_\_\_\_\_

Total Number of Beneficiaries: \_\_\_\_\_

Average Number of Services Per Beneficiary: \_\_\_\_\_

Average Payment Per Beneficiary: \_\_\_\_\_

Provider on Prepayment Review: \_\_\_\_\_

For Which Services/Procedures? \_\_\_\_\_

For What Period? \_\_\_\_\_

**Carrier Review Conducted Section**

Reason Provider Selected for Comprehensive Medical Review: \_\_\_\_\_

Areas on which Comprehensive Medical Review efforts were concentrated: \_\_\_\_\_

See attached for all procedures for which provider exceeded established norms. \_\_\_\_\_

Material Reviewed: \_\_\_\_\_

Claims Sampling Method: \_\_\_\_\_

Number of Beneficiaries: \_\_\_\_\_ Number of Months per Beneficiary: \_\_\_\_\_

Computer Printouts (Specify): \_\_\_\_\_

Medical Records (Specify): \_\_\_\_\_

Other Records (Specify): \_\_\_\_\_

Did Medical Staff Review Cases? \_\_\_\_\_ If so, what percent? \_\_\_\_\_

Contacts Made      Number of Cases Reviewed      Reason

Provider

SNF

Hospital

Beneficiary

**Documentation of ' 1879 of the Act Determinations Section**

List the evidence and rationale indicating that the provider knew or should have known that the services were not medically reasonable and necessary.

**Documentation of ' 1870 of the Act Determinations Section**

List the evidence and rationale indicating that the provider was "at fault" in causing the overpayment and that the provider is liable for the overpayment (i.e., recovery of overpayment will not be waived).

**Exhibit 13.1 - Excluded Providers**

**A - Notice to Beneficiaries**

To ensure that the notice to the beneficiary indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received a claim for services furnished by \_\_\_\_\_ on \_\_\_\_\_. Effective \_\_\_\_\_, \_\_\_\_\_ was excluded from receiving payment for items and services furnished to Medicare beneficiaries. This notice is to advise that no payment will be made for any items or services furnished by \_\_\_\_\_ if rendered more than 20 days from the date of this notice."

## **B - Notice to Others**

The Medicare Patient and Program Protection Act of 1987 provides that payment is denied for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156 of the Act. It also provides that payment cannot be denied until the supplier of the items and services has been notified of the exclusion.

If claims are submitted by a laboratory or a DME company for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156 of the Act, contractors:

- Pay the first claim submitted by the supplier and immediately give notice of the exclusion; and
- Do not pay the supplier for items or services ordered or prescribed by an excluded provider if such items or services were ordered or prescribed more than 20 days after the date of notice to the supplier, or after the effective date of the exclusion, whichever is later.

To ensure that the notice to the supplier indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received a claim for services ordered or prescribed by \_\_\_\_\_ on \_\_\_\_\_. Effective \_\_\_\_\_, \_\_\_\_\_ was excluded from receiving payment for items or services ordered or prescribed for Medicare beneficiaries. This notice is to advise that no payment will be made for any items or services ordered or prescribed by \_\_\_\_\_ if ordered or prescribed more than 20 days from the date of this notice."

## **Exhibit 14 - Contractor Denials 1862(a)(1) of the Act{tc \l1 "14 B Contractor Denials 1862(a)(1) of the Act}**

The determinations which follow a §1862(a)(1) denial may require a decision if the beneficiary or provider knew or could have known that a service would not be covered by Medicare because it would be considered medically unnecessary. The provider is liable if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. The beneficiary is liable if it is determined the beneficiary knew, or could reasonably have been expected to know (e.g. utilization review notice from a SNF) that the items or services provided were not covered under Medicare. However, the Medicare program accepts liability (i.e., makes payment to a provider even though a non-covered service is involved) if neither the beneficiary nor the provider knew, or could reasonably be

expected to have known, that the services were not covered. Waiver of liability exists when both the beneficiary and the provider did not and could not reasonably have been expected to know that payment would not be made for services.

To find that a beneficiary knew or should have known that a service would not be covered, written notice from the provider is required or evidence that the beneficiary had received a prior denial for the same or similar services. To find that a provider had knowledge that a service would not be covered, actual or constructive notice is acceptable (e.g., carrier bulletin with final LMRP and effective date). Sufficient notice includes:

- Previous denials for the same service;
- Publication by the contractor in a newsletter or other communication to the provider community that a service is considered not reasonable and necessary or constitutes custodial care;
- Knowledge based on experience; and
- Local standards of practice.

#### **14.1 - Section 1879 of the Act Determination- Limitation of Liability{tc \12 "14.1 B Section 1879 of the Act Determination- Limitation of Liability}**

Section 1879 provides relief for a beneficiary who acted in good faith in accepting services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision also applies to denials of home health services beginning July 1, 1987 and ending September 30, 1989, where the beneficiary is not homebound or does not or did not need skilled nursing care on an intermittent basis. The provision applies to all carriers determinations on all assigned claims when claims are denied (prepay or postpay) under §1862(a)(1) of the Act. Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary.

A §1879 determination regarding knowledge is part of the framework for determining whether an actual or potential overpayment exists. If a contractor determines that program payment was proper because neither the beneficiary nor the provider knew or should have known that the service was not reasonable and necessary, no overpayment exists. However, if the contractor determines that either the beneficiary or the provider knew or should have known that a service was not medically reasonable and necessary, an overpayment exists. Contractors must consider waiver of recovery of the overpayment under §1870 of the Act.

#### **A - Documentation of ' 1879 of the Act Determination**

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary/provider (i.e., demand letters) should include all §1879 determinations as to knowledge of noncoverage, both favorable and unfavorable. Document the §1879 determination in the CMR summary report.

## **B - Section 1879 of the Act Determinations and Overpayments**

An overpayment would be \$0 (zero) for postpayment denials for assigned claims and claims submitted to an intermediary from a participating provider because a determination was made that neither the beneficiary nor the provider knew or should have known the services were not covered. Program payment was appropriate. However, if the beneficiary is found to be liable under §1879 of the Act, an overpayment to the beneficiary exists and the contractor must make an §1870 determination.

### **14.2 - Section 1870 of the Act Determination - Waiver of Recovery of an Overpayment**

Once the contractor has concluded that an overpayment exists (i.e., postpayment review, including §1879 of the Act waiver determinations is complete), it makes a §1870 determination regarding waiver of recovery of the overpayment from the provider. Carriers make this determination for all claims where the provider took assignment. Section 1870, waiver of recovery, is not applicable for the provider on non-assigned postpayment §1862(a)(1) of the Act denied claims because the overpayment is a beneficiary overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program.

Section 1870 is not limited to claims under §1862(a)(1) (A) of the Act denied for not being reasonable and necessary. Section 1870 is the framework for determining whether overpayment recovery is waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived, the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. Section 1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim and this is the basis for the overpayment.

If §1879 of the Act is applicable, the §1879 determination is made first since an overpayment does not exist if payment can be made under §1879 because there was a lack of knowledge by both the beneficiary and the provider.

### **A - Documentation of ' 1870 of the Act Determination**

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or provider (i.e., demand letters) should include all §1870 refund determinations. Also, document the §1870 determination in the CMR summary report.

## **B - Section 1870 of the Act Determinations and Overpayments**

Where waiver of recovery from the provider is appropriate under §1870, the contractor must show an overpayment amount, but also indicate that recovery is being waived.

## **C - Section 1870 of the Act Determinations and Extrapolations**

If recovery of an overpayment from the provider for one or more claims is waived under §1870 (i.e., the provider was without fault), the amount waived must be included when extrapolating in order to get a true projected overpayment as to exactly how much recovery is being waived. Contractors should subtract the projected waived amount from the projected overpayment amount to get the amount the provider must repay.

### **14.3 - Section 1842(l) of the Act Determination - Refunds to Beneficiary**

For §1862(a)(1) of the Act denials on non-assigned claims involving **physician or supplier** services, carriers must make a determination under §1842(l) regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for postpayment denials.

Carriers make a §1842(l) physician or supplier refund determination if the reviewer concludes that the services were not reasonable and necessary. For physician or supplier claims where assignment was not taken, a §1842(l) refund determination must be made. Carriers must make a determination for each claim that is denied as not reasonable and necessary.

A physician or supplier cannot be considered overpaid if payment was not made to the physician for the claim. A physician or supplier who takes assignment on a claim-by-claim basis may be audited and the sample may include some non-assigned claims. Consideration of a refund on the non-assigned claims denied based on §1862(a)(1)(A) of the Act is appropriate, but a finding that a refund is appropriate does not create a Medicare overpayment.

### **A - Documentation of ' 1842(l) of the Act Determination**

The carrier must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or physician, or supplier (i.e., demand letters) should include all §1842(l) refund determinations. Document §1842(l) determinations in the CMR summary report.

### **B - Section 1842(l) of the Act Determination With Respect to Overpayments**

A physician refund obligation under §1842(l) is not a determination of a program overpayment. If the refund obligation arises in connection with a postpayment denial, any overpayment would be a beneficiary overpayment.

### **Exhibit 15 B Consent Settlement Documents**

Contractors must use these sample documents when offering consent settlements. Within these sample documents are instructions that must not be inserted in correspondence going to providers. These instructions are printed in **bold**, italics and bordered by brackets. Fill-ins

indicated by a blank line and sentences printed simply in bold are not instructions to the carrier and are to be part of the correspondence going to the provider.

Dear Doctor:

Under Section 1842(a)(1)(C) of the Social Security Act, carriers under contract to the Health Care Financing Administration are authorized to "make . . . audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

On \_\_\_\_\_, [**Fill-in date of initial request for records prior to conducting audit.**] you received our request for records to conduct an audit of your practice. The purpose of this letter and attachments is to describe the steps involved in the audit process, to highlight problems in your billing and practice patterns identified as a result of our audit, to notify you of the potential overpayment calculated as a result of our audit, and to outline three options available to you.

Our normal full-scale audit process entails the extensive review of records for a large number of randomly selected beneficiaries. However, in the interest of economy and expediency for both you and the Medicare program, as a first step, we elected to perform a limited audit. We reviewed claims and medical records for services rendered to \_\_\_\_\_ [**Fill-in the number of beneficiaries making up the sample. Fifteen (15) is the minimum number, you may elect to use a larger sample size.**] beneficiaries over a period of time, from \_\_\_\_ to \_\_\_\_\_. While beneficiaries [**A minimum of 15, you may select a larger sample size**] were randomly selected for our sample from a larger universe of beneficiaries for whom you provided services, it is not considered to be a statistically valid random sample (SVRS). A SVRS normally involves a much larger sample.

You were chosen for an audit because \_\_\_\_\_ [**Fill-in the reason for the audit. The reason may be exceeding peer norms or a call from a beneficiary. For example, if the provider exceeded peer norms the contractor might want to use the following language: "You were chosen for an audit because our records indicate you exceeded the average utilization rates of your peers by \_\_\_\_ % for the same time period. Your specialty is listed as \_\_\_\_\_. The peer group consisted of \_\_\_\_\_ who billed for the same procedure(s)."**] We selected the [**NOTE: a minimum of 15, you may select a larger sample size**] beneficiaries by identifying the procedure codes where your billing exceeded the norm for your peers. Included in the universe are only those beneficiaries for whom you rendered and billed at least one of these procedure codes that was paid by Medicare during the review period. From this universe of beneficiaries, a computer is used to randomly select the beneficiaries to be included in the sample. All claims for the procedure codes at issue that were rendered to the sampled beneficiaries and paid within the \_\_\_\_\_ time period were audited. [**Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims. As worded, all claims would have to actually been paid within the time period. Whichever method is used, you must be consistent.**] The list of sampled beneficiaries, dates of service, and procedure codes is contained in the attachment to this letter.

The [**a minimum of 15, carriers may select a larger sample size**] beneficiaries included in our audit resulted in claims being paid by Medicare between \_\_\_\_\_ and \_\_\_\_\_. [**See note in preceding paragraph. The same type of rewording could be required here.**] These claims and their corresponding medical records were audited, resulting in a potential

overpayment of \$\_\_\_\_\_ including an actual overpayment of \$\_\_\_\_\_ for the \_\_ [a **minimum of 15, carriers may select a larger sample size** ] beneficiaries. Item 3 under "Audit Results" explains how we calculated the potential overpayment. Please review the attached documents containing the audit results and options along with an explanation of the Extended Repayment Plan.

We must have your response to this letter within sixty (60) days from the date of this letter, . If we do not receive a response from you by \_\_\_\_\_, Option 3 will be chosen for you by default (see attached discussion of audit results). Be advised that by signing this letter your legal options may be affected. You may wish to have legal counsel review this letter before signing it. If you have any questions, please contact me at \_\_\_\_\_.

Sincerely,

Attachments

## **A - Consent Settlement Attachment 1 Audit Results**

### **IDENTIFYING INFORMATION**

List the following information in the heading of the attachment:

- Date;
- Provider Name;
- Provider Address; and
- Provider Number.

### **SCOPE OF AUDIT**

This audit covers services that were paid by Medicare from\_\_\_\_\_ to \_\_\_\_\_. [**Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims. As worded, all claims would have to actually been paid within the time period. Whichever method is used, you must be consistent.**]

The audit revealed the following problems in your billing and practice patterns:

### **ISSUES/DETERMINATIONS**

A physician reviewer, specializing in \_\_\_\_\_. [**You are required to have a medical specialist involved in the review of the sample claims that are not based on application of clearly articulated existing MR policy. Fill-in the specialty here. (See PIM Chapter 3 ' ' 6.4 and 6.5).**] was consulted during the audit process. The following claims and submitted records of determinations were used in the review.

[**This area lists the problem areas noted in 1.B. above, such as exceeding peer norms and medical necessity/documentation concerns. Additionally, each of the sampled beneficiaries, dates of services, procedure codes, and the Medical Director's determination on each**

denied service is noted here. Attach newsletters discussing medical policy and documentation requirements for the problem areas found during the audit.]

[This is also the area where you explain the ' 1879 and ' 1870 determinations, perhaps using, in part, the following language:

For ' 1879: "Based on available information, we believe you knew or should have known that..."

For ' 1870: "We have made the determination that you were not "without fault" in causing the overpayment. Therefore, we are not waiving your obligation to repay. We cannot find you without fault because..."

Rationale for the ' 1879 and/or ' 1870 findings might include all or part of the following language:]

"The management of a medical or supplier practice that includes a large number of Medicare beneficiaries must understand the conditions governing which services will be covered and payable under Part B of the Medicare Program. Pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of carrier newsletter], from a meeting you attended on date, and from your peers in the medical community ."

Carriers need to make specific findings for ' 1879 and ' 1870. The rationale for finding provider knowledge or fault with regard to a particular claim may not be the same as for another claim. This may be so even for multiple denials for a particular code since MN is a unique and individualized determination. These individual findings are especially important if ' 1879 and/or ' 1870 determinations are partially favorable. In such cases, specify which of the sample claims are affected, why, and how much this reduces the actual and total potential overpayment amounts (see ' 1879) or reduces the amount of the actual and total potential overpayments which must be refunded (see ' 1870).

Because ' ' 1879 and 1870 determinations are difficult concepts, it is important to explain to physicians exactly why they are being held responsible under these provisions. Your explanation must go beyond conclusory statements and/or findings.]

## **CALCULATIONS**

A copy of our calculation worksheet is enclosed for your information. To calculate the potential projected overpayment amount for each denied procedure code, the following formula was used:

[In this section, insert a complete explanation of the methodology used to calculate the overpayment and the projected overpayment for each denied procedure code. The explanation must include the formula used when the audited services were down coded rather than denied and when only one example of a procedure code was audited.]

Procedure Code	Denied Services # Sample	Denied Services # Universe	Down-coded Services #Sample	Down-coded Services #Universe	Potential Overpayment
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**[This table lists procedure codes, the number of services in the sample and in the universe that were denied or down-coded, and the resulting potential overpayment amount.]**

The actual overpayment amount is \$\_\_\_\_\_. The sum of all potential projected procedure code overpayments, including the actual overpayment amount, is \$\_\_\_\_\_.

## **OPTIONS**

You must now select one of the three options explained below. Our normal audit process entails the routine use of Option Three. However, we are now making two additional options available to you as a consent settlement.

If you fail to notify us of your selected option, Option Three (Election to Proceed to a Statistically Valid Random Sample) will automatically be selected for you by default. Be aware that when a statistically valid random sample is selected for audit, records for all of the services at issue must be available for review.

Please send in your response to the options listed below within sixty (60) days from the date of this letter, \_\_\_\_\_.

Regardless of the option selected, beneficiaries **may not be billed for any** of the overpayment amount.

### **Option One - Acceptance of Potential Projected Overpayment**

You agree to refund the entire potential overpayment amount (which includes the actual overpayment for the sample beneficiaries) of \$\_\_\_\_\_ and do not wish to submit additional medical documentation.

The potential overpayment amount may be paid by check written to \_\_\_\_\_. Any balance not paid within thirty (30) days of the date you select this option will be subject to offset, whereby future Medicare payments made to you will be withheld and applied to the potential overpayment.

You may apply for an Extended Repayment Plan (ERP) to extend the time over which the potential overpayment must be paid. Please refer to Attachment 5 for an explanation of the ERP. As explained in Item 5 below, interest will be assessed on any balance outstanding thirty (30) days from the date of your selection of this option. Your selection of this option must be received within thirty (30) days of the date of this letter, which is \_\_\_\_\_.

By selecting this option, you agree that there was a problem in your billing as identified by the carrier, you intend to correct this problem in future billings, and you understand how we reached the potential overpayment, i.e., you understand the sampling methodology used and the methodology to project the potential overpayment. Because you agree that there was a problem and agree to make changes in your practice to address this problem, you waive your right to appeal the sampled individual overpayments, the potential overpayment resulting from the projection and the sampling procedures. The appeal rights you are waiving include a hearing before a Hearing Officer, an Administrative Law Judge, or in the courts. You also waive any

rights you have under §§1870 and/or 1879 of the Social Security Act. (Please see Items 6 and 7 in this attachment for a discussion of these rights.)

Election of Option One means that, in the absence of potential fraud, we will not audit your claims for any procedure codes projected in our audit during the audit time frame again. In the event of fraud and/or if you fail to correct the identified problems, we reserve the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

### **Option Two Acceptance of Capped Potential Projected Overpayment**

You agree to repay the potential projected overpayment, after providing additional medical documentation relevant to the \_\_\_\_ [A minimum of 15, you may select a larger sample size] beneficiaries involved in our sample which was in existence at the time the services were rendered.

Review of this information will result in one of three decisions:

- All services in contention could be determined to be appropriate and allowed as originally processed, and the question of any potential overpayment would be eliminated; or
- A portion of the services in question could be determined to be appropriate and allowed as originally processed, and the amount of the potential overpayment would decrease accordingly; or
- The audit results could remain the same and the potential projected overpayment would remain at \$\_\_\_\_\_.

You may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination.

If you select Option Two, you agree to refund the revised potential overpayment amount, if any, which will not exceed the dollar amount calculated in Item 3 of this attachment and printed above.

### **The revised potential overpayment amount will not exceed the capped amount.**

The form and manner of repayment is the same as that listed under Option One. By selecting this option, you agree that there was a problem in your billing as identified by the carrier, you intend to correct this problem in future billings, and you understand how we reached the potential overpayment, i.e., you understand the sampling methodology used and the methodology to project the potential overpayment. Because you agree that there was a problem and agree to make changes in your practice to resolve this problem, you waive your right to appeal the sampled individual overpayments, the potential overpayment resulting from the projection and the sampling procedures. The appeal rights you are waiving include a hearing before a Hearing Officer, Administrative Law Judge, or in the Courts. You also waive any rights you have under §§1870 and/or 1879 of the Social Security Act. (Please see Items 6 and 7 in this attachment for a discussion of these rights.)

Election of Option Two means that, in the absence of potential fraud, we will not audit your claims for any procedure codes projected in our audit during the audit time frame again. In the event of fraud and/or if you fail to correct the identified problems, we reserve the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

### **Option Three Election to Proceed to a Statistically Valid Random Sample**

If you do not choose either Option One or Two, we will proceed with Option Three. If we do not hear from you within sixty (60) days from the date of this letter, \_\_\_\_\_, this option will be chosen for you by default. This is the second step in the audit process if you have been offered a consent settlement on a potential overpayment but do not accept the offer. This step utilizes a Statistically Valid Random Sample (SVRS) for the same universe or time period. Your right to appeal to a Hearing Officer, an administrative law judge or to the court remains if you should choose this option. Also, any rights available to you under §§1870 and/or 1879 of the Social Security Act remain.

Be aware that this option, either by your selection or by default, means that you are required to submit medical documentation for all of the services at issue in the SVRS (just as you would have had to do if we had not first offered you the opportunity for a consent settlement on a potential overpayment). You should also be aware that this option, whether selected by you or by default, withdraws the option of a consent settlement, as described in Options One and Two.

If you elect (or accept by default) Option 3, it is important that you understand the following information concerning our actions and your responsibilities with regard to the actual overpayments found for the claims involved in the limited audit:

The potential projected overpayment referred to in this correspondence is based on a sample of **[a minimum of 15, you may select a larger sample size]** beneficiaries. We audited claims and medical documentation for the \_\_\_ **[a minimum of 15, you may select a larger sample size]** beneficiaries in the sample to arrive at an actual overpayment for these claims. The actual overpayment amount was then projected to the universe of procedure codes to develop the potential projected overpayment. (See Item 3. above for the actual overpayment amount and the potential projected overpayment amount.)

Options One and Two involve repayment of the potential projected overpayment, which includes the actual overpayment amount. Choosing Option Three does not eliminate your obligation to repay the actual overpayment. Recoupment of the actual overpayment identified for the claims in the limited audit will be pursued individually, but their recovery will be credited against any projected overpayment for the universe to which the claims belong. Your obligation to repay the overpayment for these claims will begin on the date of the official notification of overpayment. You will be notified of your appeal rights on these claims at this same time.

### **ASSESSMENT OF INTEREST**

We wish to make you aware, should you elect Option One, that interest will be assessed on any balance outstanding thirty (30) days from the date of your signed selection, or, if you choose Option Two, thirty (30) days from the date of the letter notifying you of a final potential overpayment, if any. Should you choose Option 3, interest will be assessed on any balance

outstanding thirty (30) days from the date of the letter notifying you of a final overpayment determination. We must assess interest as provided in 42 CFR §405.376. Interest will accrue on the unpaid balance for each thirty (30) day period (or portion thereof) that repayment is delayed. The current interest rate is \_\_\_\_\_ %.

### **LIMITATION OF LIABILITY**

Section 1879 of the Social Security Act (42 USC §1395pp, 42 CFR §411.406) permits Medicare payment to be made to providers on assigned claims for certain services otherwise not covered because they were not reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or were custodial services if neither the beneficiary nor the provider knew, or could reasonably be expected to know, that the services were not medically necessary or were for custodial care. Services affected are those disallowed as not reasonable or necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member and those disallowed as custodial services.

### **WAIVER OF OBLIGATION TO REPAY UNDER ' 1870 OF THE SOCIAL SECURITY ACT**

Section 1870 of the Social Security Act (42 USC §1395gg, 42 CFR §405.704(b)(14)) permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. This determination is made after §1879 is considered. If it is determined that you or the beneficiary knew or should have known that the service was not medically necessary and reasonable or constituted custodial care as described under the provisions of §1879, we address §1870 and determine whether you were "without fault" with respect to causing the overpayment.

### **GENERAL**

We wish to ensure that you are aware of regulations and provisions of the law relating to continuation of the problems discussed herein. They include exclusion from the Medicare Program in accordance with §1128(b) of the Social Security Act (42 USC §1320a-7), civil monetary penalties or other actions in accordance with §1128A of the Social Security Act (42 USC 1320a-7a), and/or, if appropriate, withholding payment under 42 CFR 405.370.

**Your decision regarding this matter must be in writing and received by this office within sixty (60) days from the date of this letter. If your decision is not received by the above-mentioned date, Option 3, Election to Proceed to a Statistically Valid Random Sample, will be selected for you by default.**

We have enclosed two copies each of the three option forms for your convenience. Select one of the options, complete and sign both forms corresponding to that option, and send them to my personal attention at the address shown below.

**The provider must personally sign the forms. A signature stamp, or the signature of a staff member or attorney is not acceptable. After receipt of the two identical option forms with authorized signatures, we will sign both forms and return one to you.**

Name:

Title:

Address:

Telephone number:

## Consent Settlement Attachment 2: Acceptance of Potential Projected Overpayment

### OPTION ONE - ACCEPTANCE OF POTENTIAL PROJECTED OVERPAYMENT

I, (Name of Provider) \_\_\_\_\_:

- have read the results of the audit findings in the letter dated (Date of letter) \_\_\_\_\_.
- understand the issues the carrier presented and the calculation of the projected potential overpayment and agree to settle the issue of a potential projected overpayment by refunding \_\_\_\$(**Dollar amount**) to Medicare. This amount was derived by reviewing a sample of my claims and determining that a potential overpayment did exist within the universe of my claims.
- understand that if the settlement amount is not paid in full within thirty (30) days from the date I sign this agreement, the unpaid balance is subject to offset. I may apply for an Extended Repayment Plan and if approved, may make payments over an approved period of time.
- understand that interest on the amount accrues from the date I sign this consent agreement, but that this interest will be waived if repayment is made within thirty (30) days from the date I sign this consent agreement.
- understand that claims paid to me from (**From Date**) to (**To Date**) will not be audited in the future. [**Reword this statement to reflect service dates if service dates were used in the audit to select claims instead of dates of payment.**] I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

I, (Name of Provider) \_\_\_\_\_, agree by settling this:

- That my right to appeal, which includes a Medicare Part B hearing officer hearing, administrative law judge hearing, or any court appeals regarding this matter, is waived. I also understand any rights available to me under §§1879 and/or 1870 of the Social Security Act are waived.

Provider signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Printed or typed name: \_\_\_\_\_

Title of signatory: \_\_\_\_\_

Carrier Representative Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Printed or typed name: \_\_\_\_\_

Title of signatory: \_\_\_\_\_

Overpayment instructions will be provided upon Medicare's receipt of the signed option agreement.

Please do not enclose a check with the option form.

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

## **CONSENT SETTLEMENT ATTACHMENT 3 OPTION TWO - ACCEPTANCE OF CAPPED POTENTIAL PROJECTED OVERPAYMENT**

Option Two - Acceptance of Capped Potential Projected Overpayment

I, \_\_\_\_\_:

- have read the results of the audit findings in the letter dated \_\_\_\_\_.
- understand the issues the carrier presented and the calculation of the projected potential overpayment and agree to settle the issue of a potential projected overpayment by refunding a redetermined amount of up to \$\_\_\_\_\_ to Medicare. This amount was derived by reviewing a sample of my claims and determining that a potential overpayment did exist within the universe of my claims.
- have enclosed additional documentation for you to review for the purpose of redetermining the potential overpayment. I understand that I may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination. I understand the redetermined potential overpayment, if any, will not exceed the amount shown above.
- understand that if the redetermined settlement amount is not refunded to Medicare within thirty (30) days from the date of the redetermined potential overpayment notice, the unpaid balance is subject to offset. I may apply for an extended repayment plan and, if approved, may make payments over an approved period of time.
- understand that interest on the amount accrues from the date of the final potential overpayment determination, but that this interest will be waived if repayment is made within thirty (30) days from the date of the final potential overpayment determination.
- understand that claims paid to me from \_\_\_\_\_ to \_\_\_\_\_ will not be audited in the future. **[Reword this statement to reflect services dates if service dates were used in the audit to select claims instead of dates of payment.]** I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

I, \_\_\_\_\_, agree by settling this:

- that my right to appeal, which includes a Medicare Part B hearing officer hearing, administrative law judge hearing, or any court appeals regarding this matter, is waived. I also understand any rights available to me under §§1879 and/or 1870 of the Social Security Act are waived.

I, \_\_\_\_\_, do/do not (circle one) wish to request a meeting at this time to discuss the additional documentation I have submitted.

Provider signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Printed or typed name: \_\_\_\_\_

Title of signatory: \_\_\_\_\_

Carrier Representative Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Printed or typed name: \_\_\_\_\_

Title of signatory: \_\_\_\_\_

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

### **CONSENT SETTLEMENT ATTACHMENT 4: OPTION THREE - ELECTION TO PROCEED TO A STATISTICALLY VALID RANDOM SAMPLE**

Option Three - Election to Proceed to a Statistically Valid Random Sample

I, \_\_\_\_\_:

- have read the results of the audit findings in the letter dated \_\_\_\_\_.
- elect to proceed to your full-scale audit process, involving a Statistically Valid Random Sample (SVRS) for the same universe of procedure codes and time period as the limited audit, as explained in the letter. I understand the full-scale audit process is the normal audit process, and that the limited audit was offered to me only in the interest of economy and expediency. Upon selection of Option Three, I understand that the offer of a consent settlement as stated in Options One and Two is withdrawn.
- understand that I and/or my office staff will be required to submit medical documentation for all services at issue in the SVRS, upon request by the carrier.
- understand that all applicable appeals rights, including any right to a hearing officer hearing, an administrative law judge hearing, or court review are available to me. I also retain any rights available under §§1879 and/or 1870 of the Social Security Act, as appropriate.
- understand that the claims from the above-referenced limited audit will not be selected for inclusion in the SVRS; the SVRS will be a new and independent audit.

- understand that the overpayment identified for claims in the limited audit will be pursued on an individual basis, and that this overpayment will be subtracted from any overpayment resulting from the SVRS; that I will be provided with appeal rights regarding the overpayment amount on the claims in the limited audit at a later date; and that any interest on the overpayment amount on the claims in the limited audit will be calculated from the date of this later notice with appeal rights.

Provider signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Printed or typed name: \_\_\_\_\_

Title of signatory: \_\_\_\_\_

Carrier Representative Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Printed or typed name: \_\_\_\_\_

Title of signatory: \_\_\_\_\_

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

## **CONSENT SETTLEMENT ATTACHMENT 5: EXTENDED REPAYMENT PLAN (ERP)**

It has been determined by an audit that there is a potential overpayment amount due to Medicare. It is expected that you will remit the entire amount in one payment within thirty (30) days of the date you sign Consent Agreement Option One (Acceptance of Potential Projected Overpayment) or, if you select Consent Agreement Option Two (Acceptance of Capped Potential Projected Overpayment), the date of the final potential overpayment determination, or, if you select Option Three (Election to Proceed to a Statistically Valid Random Sample), the date of the final overpayment determination. However, if you are unable to repay the amount within that time, we are authorized to consider repayment in installments based on validated financial hardship.

**[Installments are based on the amount of the overpayment as stated in MCM ' 7160.2.]**

Installments can range from 2-6 months based on the amount of overpayment. Be aware that if repayment is not made within thirty (30) days, interest will be due. For Option One, interest accrues from the date you sign Consent Agreement Option One or, if you select Consent Agreement Option Two, interest accrues from the date of the final potential overpayment determination, or if you elect Option Three, interest accrues from the date of the final overpayment determination (See 42 CFR 405.376.). Interest will be waived if repayment is made within thirty (30) days of the applicable date cited above for the option chosen. The current rate of interest is \_\_\_\_\_ percent. If you wish to claim financial hardship, contact \_\_\_\_\_ to obtain the financial statement of debtor form (HCFA-379). This form must be completed and returned with your request for approval of an installment schedule. If compliance with the above is not acceptable to you, it is suggested that you seek a private or commercial loan to satisfy the obligation.

If repayment of the amount due, in a lump sum or on an approved installment plan, is not forthcoming, the Health Care Financing Administration may, at its option, forward the case to the Department of Justice or the Internal Revenue Service (IRS) for enforced collection.

# **Exhibit 16 - Model Suspension of Payment Letters {tc \l1 "16 B Model Suspension of Payment Letters }**

## **A - Letter Number 1: Notice Concurrent with Effective Date of Suspension, Reason Number 1, Suspected Overpayment**

[DATE]

[NAME AND ADDRESS OF PROVIDER]

RE: Notice of Suspension of Medicare Payments to [PROVIDER]

Dear [PROVIDER]:

The purpose of this letter is to notify you that your Medicare payments have been suspended today pursuant to 42 CFR 405.371(a). This suspension of your Medicare payments may last up to 180 days from the date of this letter and may be extended under certain circumstances. (See 42 CFR 405.372(d).) The Health Care Financing Administration (HCFA), through its Regional Office in [REGIONAL OFFICE CITY], is responsible for the decision to suspend your Medicare payments. HCFA's decision to suspend payments is not appealable per 42 CFR 405.375(c). The suspension of your Medicare payments is based on reliable information that an overpayment exists. [LIST THE SPECIFIC SOURCE AND NATURE OF THE RELIABLE INFORMATION ON WHICH THE SUSPENSION DECISION IS BASED.]

Based on our review, we have determined that an overpayment may exist. Therefore, we are suspending your Medicare payments effective with the date of this letter.

During the suspension period, we will review additional evidence to determine whether an overpayment exists, and if so, the amount of the overpayment. (See 42 CFR 405.372(c).) We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. We will continue to process bills/claims during the suspension period and will notify you about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. However, we will not make payment as long as suspension is in effect. We will apply suspended funds to recoup any determined overpayment.

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing addressing why the suspension should be removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]

[TITLE]

[AGENCY]

CITY, STATE, ZIP]

TELEPHONE NUMBER]

[FAX NUMBER]

Upon receipt of your rebuttal statement and any supporting evidence, we will consider and determine within fifteen (15) days whether the facts justify termination of the suspension per 42

CFR 405.375(a). We will send you separate written notice of our determination to either continue or terminate the suspension that began today. (See 42 CFR 405.375(b)(2).) This separate notice will contain specific findings on the conditions by which your suspension is continued or terminated, as well as an explanatory statement of the determination. If you have any questions, please contact me at [TELEPHONE NUMBER].

Sincerely,

[NAME]  
[TITLE]  
[AGENCY]  
[MAILING ADDRESS]  
[CITY, STATE, ZIP]  
[TELEPHONE NUMBER]  
[FAX NUMBER]

## **B - Letter Number 2: Notice Prior to Suspension, Reason Number 2, Fraud or Willful Misrepresentation**

[DATE]  
[NAME AND ADDRESS OF PROVIDER]

RE: Notice of Suspension of Medicare Payments to [PROVIDER]

Dear [PROVIDER]:

The purpose of this letter is to notify you of our intent to suspend your Medicare payments pursuant to 42 CFR 405.371(a). The suspension of your Medicare payments will take effect fifteen (15) days from the date of this letter [OR SPECIFY DATE]. The suspension of your Medicare payments may last up to 180 days from the date of this letter and may be extended under certain circumstances. (See 42 CFR 405.372(d).)

The Health Care Financing Administration (HCFA), through its Regional Office in [REGIONAL OFFICE CITY], is responsible for the decision to suspend your Medicare payments. HCFA's decision to suspend payments is not appealable per 42 CFR 405.375(c). We will apply suspended funds to recoup any determined overpayment.

The suspension of your Medicare payments is based on reliable information that bills/claims you submitted for Medicare payment involved fraud or misrepresentation. Specifically, [LIST SPECIFICS OF RELIABLE INFORMATION ON WHICH SUSPENSION DECISION IS BASED.]

[THE FOLLOWING EXAMPLES ILLUSTRATE THE LEVEL OF DETAIL WHICH IS EXPECTED.]

(EXAMPLE #1) On [DATE], the Office of Inspector General (OIG), United States Department of Health and Human Services, executed search warrants at the administrative office address of [PROVIDER]. Evidence obtained by search warrant indicates that Medicare payments made to your facility may involve fraudulent billing or misrepresentation to the Medicare program.

Specifically, evidence obtained by search warrant suggests that personal expenses may have been made to appear that they represented legitimate business expenditures. Examples of apparent fraudulent billing and misrepresented costs include, but are not limited to, the following:

1. On July 11 and 17, 1997, a total of \$640.00 was allegedly spent on postage stamps for business use but was actually used for personal cash needs.
2. In June 1997, you wrote a check of \$2467.00 as payment to your personal credit card when these funds were made to appear as if they were used to meet a number of your agency's business expenses.

(EXAMPLE #2) On [DATE], the Office of Inspector General (OIG), United States Department of Health and Human Services, executed search warrants at the above referenced address, which is the business address of [PROVIDER]. Evidence obtained by search warrant indicates that Medicare payments made to your facility may involve fraudulent billing or misrepresentation to the Medicare program. Examples of apparent fraudulent billing and misrepresented costs include, but are not limited to, the following:

1. Review of your 1995 cost report reveals that you claimed costs of \$4200.77 for computer supplies. These funds were apparently spent for lodging and entertainment in Keystone, CO.
2. In 1997, you claimed a total of \$2688.00 for seminar expenses when these funds were apparently spent on beauty pageant expenses.
3. Review of your 1995 cost report indicates that you claimed costs of \$253.31 for office supplies. These funds were apparently spent for clothing at a local retail store.

(END OF EXAMPLES)

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing addressing why the suspension should not be initiated or should be removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be initiated or should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]  
[TITLE]  
[AGENCY]  
[MAILING ADDRESS]  
[CITY, STATE, ZIP]  
[TELEPHONE NUMBER]  
[FAX NUMBER]

After we receive your rebuttal statement and evidence, we will determine within fifteen (15) days whether the facts justify initiating the suspension as described above per 42 CFR 405.375(a).

However, the decision to suspend Medicare funds will not be delayed beyond the date specified in this notice while your statement is being reviewed. (See 42 CFR 405.375(a).) We will send

you separate written notice of our determination not to initiate, or to continue, or to terminate the suspension. (See 42 CFR 405.375(b).) This separate notice will contain specific findings on the conditions by which your facility's suspension is continued or removed, as well as an explanatory statement of the determination.

If we initiate suspension, we will review additional evidence during the suspension period to determine whether an overpayment exists, and if so, the amount of the overpayment. (See 42 CFR 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. We will continue to process bills/claims during the suspension period and will notify you about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. However, we will not make payment as long as the suspension is in effect. We will apply suspended funds to recoup any determined overpayments pursuant to 42 CFR 405.372(e).

If you have any questions, please contact me at [TELEPHONE NUMBER].

Sincerely,

[NAME]  
[TITLE]  
[AGENCY]  
[MAILING ADDRESS]  
[CITY, STATE, ZIP]  
[TELEPHONE NUMBER][FAX NUMBER]

### **C - Letter Number 3: Notice Prior to Suspension, Reason Number 3, Incorrect Payment**

[DATE]  
[NAME AND ADDRESS OF PROVIDER]  
RE: Notice of Suspension of Medicare Payments to [PROVIDER]

Dear [PROVIDER]:

The purpose of this letter is to notify you of our intent to suspend your Medicare payments pursuant to 42 CFR 405.371(a). The suspension of your Medicare payments will take effect fifteen (15) days from the date of this letter [OR SPECIFY DATE]. The suspension of your Medicare payments may last up to 180 days from the date of this letter and may be extended under certain circumstances per 42 CFR 405.372(d).

The Health Care Financing Administration (HCFA), through its Regional Office in [REGIONAL OFFICE CITY], is responsible for the decision to suspend your Medicare payments. HCFA's decision to suspend payments is not appealable. (See 42 CFR 405.375(c).) We will apply suspended funds to recoup any determined overpayment.

The suspension of your Medicare payments is based on reliable information that you may be submitting non-covered or miscoded bills/claims. Specifically, [LIST SPECIFICS OF RELIABLE INFORMATION ON WHICH SUSPENSION DECISION IS BASED.]

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing addressing why the suspension should not be initiated, or should be removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be initiated or should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]  
[TITLE]  
[AGENCY]  
[MAILING ADDRESS]  
[CITY, STATE, ZIP]  
[TELEPHONE NUMBER]  
[FAX NUMBER]

After we receive your rebuttal statement and evidence, we will determine within fifteen (15) days whether the facts justify initiating the suspension as described above per 42 CFR 405.375(a). However, the decision to suspend Medicare funds will not be delayed beyond the date specified in this notice while your statement is being reviewed. (See 42 CFR 375(a).) We will send you separate written notice of our determination not to initiate, or to continue, or to terminate the suspension per 42 CFR 405.375(b). This separate notice will contain specific findings on the conditions by which your suspension is continued or removed, as well as an explanatory statement of the determination.

If we initiate suspension, we will review additional evidence during the suspension period to determine whether an overpayment exists, and if so, the amount of the overpayment pursuant to 42 CFR 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. We will continue to process bills/claims during the suspension period and will notify you about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. However, we will not make payment as long as the suspension is in effect. We will apply suspended funds to recoup any determined overpayments pursuant to 42 CFR 405.372(e).

If you have any questions, please contact me at [TELEPHONE NUMBER].

Sincerely,

[NAME]  
[TITLE]  
[AGENCY]  
[MAILING ADDRESS]  
[CITY, STATE, ZIP]  
[TELEPHONE NUMBER]  
[FAX NUMBER]

**D - Letter Number 4: Notice Prior to Suspension, Reason Number 4, Failure to Furnish Information**

[DATE]  
[NAME AND ADDRESS OF PROVIDER]

RE: Notice of Suspension of Medicare Payments to [PROVIDER]

Dear [PROVIDER]:

The purpose of this letter is to notify you of our intent to suspend your Medicare payments pursuant to 42 CFR 405.371(a) (61 Fed. Reg. 63740, Dec. 2, 1996). The suspension of your Medicare payments will take effect fifteen (15) days from the date of this letter [OR SPECIFY DATE]. The suspension of your Medicare payments may last up to 180 days from the date of this letter and may be extended under certain circumstances pursuant to 42 CFR 405.372(d).

The Health Care Financing Administration (HCFA), through its Regional Office in [REGIONAL OFFICE CITY], is responsible for the decision to suspend your Medicare payments. HCFA's decision to suspend payments is not appealable per 42 CFR 405.375(c). We will apply suspended funds to recoup any determined overpayment.

The suspension of your Medicare payments is based on reliable information that an overpayment exists, and that pending payments may be incorrect. Specifically, [LIST SPECIFICS OF FI AUDIT OR OTHER RELIABLE INFORMATION ON WHICH SUSPENSION DECISION IS BASED.]

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing addressing why the suspension should not be initiated, or should be removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be initiated, or should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]  
[TITLE]  
[AGENCY]  
[MAILING ADDRESS]  
[CITY, STATE, ZIP]  
[TELEPHONE NUMBER]  
[FAX NUMBER]

After we receive your rebuttal statement and evidence, we will determine within fifteen (15) days whether the facts justify initiating the suspension as described above. (See 42 CFR 405.375(a).)

However, the decision to suspend Medicare funds will not be delayed beyond the date specified in this notice while your statement is being reviewed per 42 CFR 405.375(a). We will send you separate written notice of our determination not to initiate, or to continue, or to terminate the suspension per 42 CFR 405.375(b). This separate notice will contain specific findings on the conditions by which your facility's suspension is continued or removed, as well as an explanatory statement of the determination.

If we initiate suspension, we will review additional evidence during the suspension period to determine whether an overpayment exists, and if so, the amount of the overpayment. (See 42 CFR 405.372(c).) We may need to contact you with specific requests for further information.

You will be informed of developments and will be promptly notified of any overpayment determination. We will continue to process bills/claims during the suspension period and will

notify you about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. However, we will not make payment as long as the suspension is in effect. We will apply suspended funds to recoup any determined overpayments pursuant to 42 CFR 405.372(e). If you have any questions, please contact me at [TELEPHONE NUMBER].

Sincerely,

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

## **16.1 - OIG/OI Case Referral Fact Sheet Format**

<u>Heading</u>	<u>Description of Information to Include</u>
Subject's Name	Provider/Physician/Supplier/Individual/Corporation
Allegation	Simply stated (kickback/false claims, etc.)
Source of Complaint	Simply stated - (beneficiary/competitor/OIG)
Contractor Investigator - (Contact person)	If the contact person is not the case investigator, include both the contact person and the investigator's names and telephone numbers. Also include the reference number, if applicable (OI case number if assigned by the RO).
Subject's Address	Home; and Office/Business
Corporate/Business Name Used	If other than subject's name
Overpayment Estimate (if known or calculated)	
History of Contact with OIG	List all contacts with OIG and note any guidance given

## **16.2 - OIG/OI Case Summary Format**

<u>Heading</u>	<u>Description of Information to Include</u>
Summary of Original Allegations/Complaint Source	Date complaint was received; who made complaints; how actions were taken to corroborate information (pulled bills and payment information, contacted complainant); overpayment identified by complaint.
Citations	Code of Federal Regulation; Manual Provisions
Identify the Amount of the Actual Overpayment Established	Detail claim information related to allegation; i.e., number of claims submitted/paid; amount paid/ procedure codes involved; pertinent profile information.
Estimated Additional Overpayment/Scope of Alleged Fraud	Be specific on how this estimated amount was determined, i.e., billing for specialized procedure and the total number of these procedures that were billed; therefore, if all were false, the overpayment would be \$_____ dollars.
Billing Information (Last 3 Years)	(Report Data For Questions Procedures and Total Billings)19__ 19__ 19__ <ul style="list-style-type: none"> <li>• Total covered charges-Part A;</li> <li>• Total non-covered charges;</li> <li>• Total DRG payments;</li> <li>• Total Admissions; and,</li> <li>• Total Medicare admissions.</li> <li>• National pass-through costs, SNF or HHAs - Under reasonable cost payment (last 3 years):</li> <li>• Total costs;</li> <li>• Total allowable costs;</li> <li>• Total Medicare payment;</li> <li>• Total patient days; and</li> <li>• Total Medicare patient days.</li> </ul>
Medicare Coverage/Intermediary Payment Guidelines	Be specific as to the Medicare coverage issue involved. Define necessary medical terms and describe the necessary medical procedures in layman's terms. Procedure code description.

<u>Heading</u>	<u>Description of Information to Include</u>
Summarized	
Identify Copies of All Correspondence, Newsletters, Publications	Briefly summarize all newsletters, publications, and/or correspondence related to the issue at hand. Attach a copy of each.
Additional Development	<ul style="list-style-type: none"> <li>• Summarize the information received through interviews that corroborate the original complaint. Attach interview reports and copies of Medicare claims used to arrive at this summary.</li> <li>• Summarize new allegations identified. Attach interview reports and copies of Medicare claims used to arrive at this summary.</li> <li>• Summarize the information obtained that appears to refute the original allegation or new allegations identified.</li> </ul>
Background Information on Subject	Date of birth; any known disabilities; schools attended; State licenses; number of employees and names; previous investigation by contractor; previous complaint history; all other pertinent information.
Telephone Number(s)	
Specialty	
EIN/SSN	(Include <b>ALL</b> tax identification numbers)
Provider Number(s)	Date Issued; Related Numbers; and, Application (If required)
Details of Past Complaints (If Identified Above)	Summarize complaint history, including the details of actions taken and all other pertinent information.
Detailed Correspondence History with Subject	<ul style="list-style-type: none"> <li>• Summarize all direct correspondence with subject regarding the allegation at hand (if contacted) and/or all other correspondence related to allegation(s) at hand.</li> <li>• Alert OI to any congressional or press interest, or any public relations problem.</li> </ul>
Other Agencies Involved	<ul style="list-style-type: none"> <li>• If a referral has been made to any other agency, such as the licensing board of a State or a State Medicaid agency, show</li> </ul>

Heading

Description of Information to Include

when it was done and who that material was directed to. Attach any correspondence sent to those agencies; and

- If aware of any other agency investigating the subject, include that information.

Other Pertinent Information

- Is this provider/facility a member of a chain within and/or outside the area? If so, identify the chain and all other facilities it owns or manages in the area;
- List all related organizations. Specify whether they were identified by the provider or uncovered through audit;
- What is the subject's filing history? Were the bills denied? Why? Were the denials appealed? Who requested an appeal, and through what mechanism was the appeal requested? What was the outcome of the appeal? Were determinations made by a Hearing Officer and/or an Administrative Law Judge;
- Was a review of services done on the areas where this subject exceeded the norm of his peers? For example, if the complaint was for non-rendered lab work, did the subject exceed the norm in that area? List the areas as items that may need to be investigated; and
- List other items known that would assist the OIG in evaluating this case.

**Complaints by current or former employees of the subject should always be considered for immediate contact with the office of investigations.** OI may wish the contractor to restrict its case development to internal research.

List of Attachments

If additional information is needed, OI may request assistance. Where potential violations are detected in one facility of a chain, all intermediaries dealing with other members of the chain are alerted to the situation by the respective OIs. The MFIS notifies the RO, other carriers and intermediaries, and other State and local agencies within their network. If the problem extends beyond the MFIS's network, other MFIS s are contacted.

Retain a copy of the summary in the case file.

**Exhibit 17 - Medicare Fraud Unit Managers {tc "17 – Medicare Fraud Unit Managers" }**

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Email: [rriii@sprynet.com](mailto:rriii@sprynet.com)

**State Service Area: Part A - CA, NV; RHHI - CA, NV, AZ, OR, WA, HI, AK, ID**

**Kathleen Casey**

Cahaba GBA  
12052 Middleground Road  
Savannah, Georgia 31419  
(912) 921-3046  
FAX (912) 927-6946  
Email: [kryan@bcbsal.org](mailto:kryan@bcbsal.org)

**State Service Area: Georgia**

**Ron Shugar**

Transamerica Medicare Payment Safeguard  
1301 5th Avenue, Ste. 1300  
Seattle, Washington 98101-2610  
(206) 442-4990  
FAX: (206) 442-4995  
Email: [Ronald.Shugar@transamerica.com](mailto:Ronald.Shugar@transamerica.com)

**State Service Area: AK, ID, OR, WA**

John Sullivan  
National Heritage Insurance Company  
75 Sargent William Terry Drive  
Hingham, Massachusetts 02043  
(781) 741-3121  
FAX: (781) 741-3283  
Email: [John.Sullivan@eds.com](mailto:John.Sullivan@eds.com)

**State Service Area: Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island**

**Craig Swartz**

Xact Medicare Services  
PO Box 890008  
Camp Hill, Pennsylvania 17089-0008  
(717) 730-1474

FAX: (717) 730-1335

Email: [craig.swartz@xact.org](mailto:craig.swartz@xact.org)

**State Service Area: PA, NJ (until 3/31/99)**

**Wayne Van Halem**

Palmetto Government Benefits Administration

PO Box 100236

Columbia, South Carolina 29202-3236

(803) 788-0222, Ext 38209

FAX: (803) 691-8783

Email: [wayne.van.halem@pgba.com](mailto:wayne.van.halem@pgba.com)

**State Service Area: RHHI - VT, RI, CT, ME, MA, MS, NH, AL, FL, GA, KY, LA, NM, OK, TX, AR, NC, TN, SC, IL, IN, OH**

**Vacant**

Nationwide Insurance Company

P. O. Box 182703

Columbus, Ohio 43218-2703

(614) 249-8435

FAX (614) 677-4618

Email: None

**State Service Area: Ohio and West Virginia**

**Exhibit 19 - Durable Medical Equipment Regional Carrier Program Integrity Coordinators (PICs){tc "19 – Durable Medical Equipment Regional Carrier Program Integrity Coordinators (PICs)" }**

**A - Region A**

**Laurie Maniscalco**

United Health Care

Medicare Fraud and Abuse Unit

538 Preston Avenue

Meriden, Connecticut 06454-9000

(203) 639-3170

FAX (203) 639-3018

**B - Region B**

**Mary Beach**

AdminaStar Federal

Medicare Fraud and Abuse Unit

P.O. Box 6128 (46206-6128)

8115 Knue Road

Indianapolis, Indiana 46250

(317) 841-4470  
FAX (317) 841-4600

### **C - Region C**

#### **Don Schmadel**

Palmetto Government Benefits Administration  
Medicare Fraud and Abuse Unit  
P.O. Box 100236 (29202-3236)  
Building 200  
8901 Farrow Road  
Columbia, South Carolina 29223  
(803) 788-0222 ext. 41403  
FAX (803) 699-8624

### **D - Region D**

#### **Vince Malone**

Connecticut General Life Insurance Company (CIGNA)  
DMERC Fraud and Abuse Unit  
P.O. Box 690  
Metro Exchange Building  
2nd Floor  
2 Vantage Way  
Nashville, Tennessee 37202  
(615) 782-4596  
FAX (615) 782-4694

## **Exhibit 20 - Durable Medical Equipment Regional Carrier Jurisdictions {tc "20 – Durable Medical Equipment Regional Carrier Jurisdictions" }**

### **A - Region A - United Healthcare**

Maine	Vermont	New Hampshire	Massachusetts
Rhode Island	Connecticut	New York	New Jersey
Pennsylvania	Delaware		

### **B - Region B - Administar Federal**

Maryland	Washington, D.C.	Virginia	West Virginia
Ohio	Indiana	Illinois	Wisconsin
Minnesota	Michigan		

**C - Region C - Palmetto Government Benefits Administration**

North Carolina	South Carolina	Georgia	Florida
Alabama	Mississippi	Kentucky	Arkansas
Louisiana	Oklahoma	New Mexico	Colorado
Texas			

**D - Region D - Connecticut General Life Insurance Co. (CIGNA)**

Tennessee	Alaska	Montana	Hawaii
Iowa	Washington	Kansas	California
Nebraska	Nevada	South Dakota	Oregon
North Dakota	Missouri	Wyoming	Utah
Arizona	Idaho		

**Exhibit 21 – Regional Home Health Intermediaries/Jurisdictions {tc "21 – Regional Home Health Intermediaries/Jurisdictions" }**

**Associated Hospital Services of Maine**

Connecticut	Maine	Massachusetts
New Hampshire	Rhode Island	Vermont

**Palmetto Government Benefits Administration**

Alabama	Arkansas	Florida
Georgia	Illinois	Indiana
Kentucky	Louisiana	Mississippi
New Mexico	North Carolina	Ohio
Oklahoma	South Carolina	Tennessee
Texas		

**Blue Cross of California**

Alaska	American Samoa	Arizona
California	Guan	Hawaii
Idaho	Nevada	Northern Mariana Islands

Oregon	Washington	
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**United Government Services**

Michigan	Minnesota	New Jersey	New York
Puerto Rico	Virgin Islands	Wisconsin	

**Wellmark, Inc**

Colorado	Delaware	District of Columbia	Iowa
Kansas	Maryland	Missouri	Montana
Nebraska	North Dakota	Pennsylvania	South Dakota
Utah	Virginia	West Virginia	Wyoming

**Exhibit 22 - Office of Inspector General, Office of Investigations  
Field Offices{tc "22 – Office of Inspector General, Office of  
Investigations Field Offices" }**

Street Address	Mailing Address	States
BOSTON: Room 1405 JFK Federal Bldg. Boston, MA 02203 (617) 565-2660	HHS, OS, OIG, OI P.O. Box 8767 Boston, MA 02114	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
NEW YORK Room 3900 B Federal Building New York, NY 10278 (212) 264-1691	HHS, OS, OIG, OI P.O. Box 3209 Church St. Station New York, NY 10008	New Jersey New York Puerto Rico Virgin Islands
PHILADELPHIA Room 4430 3535 Market Street Philadelphia, PA 19104 (215) 596-6796	HHS, OS, OIG, OI P.O. Box 8049 Philadelphia, PA 19101	Delaware Pennsylvania West Virginia Maryland Except: - Prince Georges County - Montgomery County Virginia Except: -Fairfax County -Arlington County - City of Alexandria - City of Falls Church
ATLANTA	HHS, OS, OIG, OI	Alabama

Room 1404 101 Marietta Tower Atlanta, GA 30323 (404) 331-2131/2556	P.O. Box 2288 Atlanta, GA 30301	Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee
CHICAGO 23 <sup>rd</sup> Floor 105 West Adams St. Chicago, IL 60603 (312) 353- 2740	HHS, OS, OIG, OI 23 <sup>rd</sup> Floor 105 West Adams Street Chicago, IL 60603	Illinois Indiana Michigan Minnesota Ohio Wisconsin Missouri Iowa
DALLAS Room 4E1B 1100 commerce St. Dallas, TX 75242 (214) 767-8406	HHS, OS, OIG, OI Room 4E1B 1100 Commerce St. Dallas, TX 75242	Arkansas Louisiana New Mexico Oklahoma Texas
DENVER Room 327 1961 Stout Street Federal Office Bldg. Denver, CO 80294-3546 (303) 844-5621	HHS, OS, OIG, OI 1961 Stout Street Denver, CO 80294-3546	Colorado Kansas Montana Nebraska North Dakota South Dakota Wyoming Utah
SAN FRANCISCO Room 174 50 U.N. Plaza San Francisco, CA 94102 (415) 556-8880	HHS, OS, OIG, OI P.O. Box 42516 San Francisco, CA 94142-2516	Arizona California Guam Hawaii Nevada Samoa
SEATTLE SUB OFFICE Room 209, RX-81 2201 Sixth Avenue Seattle, WA 98121 (206) 442-0547	HHS, OS, OIG, OI P.O. Box 61220 Seattle, WA 98121	Alaska Idaho Oregon Washington
WASHINGTON, D.C. Field Office Room 5193 Cohen Bldg. 330 Independence Av. SW Washington, DC 20201 (202) 619-1900	HHS, OS, OIG, OI Room 5193 Cohen Bldg. 330 Independence Av SW Washington, DC 20201	District of Columbia Maryland Counties: - Prince Georges - Montgomery Counties - Virginia Counties Virginia Cities - Alexandria - Falls Church

## Exhibit 23 - PIM Acronyms

<u>Acronym</u>	<u>Meaning</u>
ABG	Arterial Blood Gas
ABN	Advanced Beneficiary Notice
ADL	Activities of Daily Living
ADMC	Advance Determination of Medicare Coverage
AIDE	Home Health Aide
AKA	Also Known As
ALJ	Administrative Law Judge
AMA	American Medical Association
AoA	Administration on Aging
ASC	Ambulatory Surgical Center
AUSA	Assistant United States Attorney
BESS	Part B Extract Summary System
BI	Benefit Integrity
CAC	Carrier Advisory Committee
CBR	Cost Benefit Ratio
CFO	Chief Financial Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMD	Contractor Medical Director
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMPL	Civil Monetary Penalties Law
CMR	Comprehensive Medical Review
CO	Central Office
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CPE	Contractor Performance Evaluation
CPT	Current Procedural Terminology
CWF	Common working File
DAP	DMERC Advisory Panel
DBA	Doing Business As
DHHS	Department of Health and Human Services

<b><u>Acronym</u></b>	<b><u>Meaning</u></b>
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, and Orthotic Supplier
DMERC	Durable Medical Equipment Regional Carrier
DOJ	Department of Justice
DRG	Diagnosis Related Groups
DX	Diagnosis
EMC	Electronic Media Claims
EOMB	Explanation of Medicare Benefits
EPO	Epoetin
ESRD	End Stage Renal Dialysis
FBI	Federal Bureau of Investigation
FHIBA	Federal Health Insurance Benefits Accounts
FI	Fiscal Intermediary
FID	Fraud Investigation Database
FMR	Focused Medical Review
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office
GPRA	Government Performance Results Act
HCFA	Health Care Financing Administration
HCIS	HCFA's Customer Information System
HCPCS	HCFA Common Procedure Coding System
HHA	Home Health Agency
HHS	Health and Human Services
HI	Health Insurance
HICN	Health Insurance Claim Number
HO	Hearings Officer
ICN/DCN	Internal Control Number/Document Control Number
IER	Interim Expenditure Report
IRP	Incentive Reward Program
IRS	Internal Revenue Service
LMRP	Local Medical Review Policy

<b><u>Acronym</u></b>	<b><u>Meaning</u></b>
MCM	Medicare Carrier Manual
MFCU	Medicaid Fraud Control Unit
MFIS	Medicare Fraud Information Specialist
MFSR	Medicare Focused Medical Review Status
MIM	Medicare Intermediary Manual
MIP	Medicare Integrity Program
MIP-PET	Medicare Integrity Program-Provider Education and Training
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSS	Medical social Services
N/A	Not Applicable
NCP	National Coverage Policy
NMFA	National Medicare Fraud Alert
NOU	Notice of Utilization
NPR	National Performance Review
NSC	National Supplier Clearinghouse
OCFAA	Office of Civil Fraud and Administrative Adjudication
OCSQ	Office of Clinical Standards and Quality
OIFO	Office of Investigations Field Office
OIG	Office of Inspector General
OIGOAS	Office of Inspector General Office of Audit Services
OIG/OI	Office of Inspector General Office of Investigations
OP	Outpatient
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
PAL	Provider Audit List
PI	Program Integrity
PIM	Program Integrity Manual
PIN	Provider Identification Number
PIP	Periodic Interim Payments
PM	Program Memorandum
PM-PET	Program Management-Provider Education and Training

<b><u>Acronym</u></b>	<b><u>Meaning</u></b>
POC	Plan of Care
PPAC	Practicing Physicians Advisory Council
PPS	Prospective Payment System
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board
PS&R	Provider Statistical and Reimbursement
PT	Physical Therapy
PTS	Provider Tracking system
QA	Quality Assurance
RBS	Report of Benefit Savings
RCCO	Regional Chief Counsel's Office
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RMFA	Restricted Medicare Fraud alert
RMRP	Regional Medical Review Policy
RO	Regional Office
ROM	Range of Motion
RRB	Railroad Retirement Board
RT	Record Type
RVU	Relative Value Unit
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SLP	Speech-Language Pathology
SMI	Supplementary Medical Insurance
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SOC	Start of Care
SSA	Social Security Administration
SSAFO	Social Security Administration Field Office
ST	Speech Therapy
SUR	State Utilization Review Units
SVRS	Statistically Valid Random Sample
the Act	the Social Security Act

<b><u>Acronym</u></b>	<b><u>Meaning</u></b>
TOB	Type of Bill
TPN	Total Parenteral Nutrition
UPIN	Unique Physician Identification Number

**Exhibit 24 - HCFA Forms 700 and 701**

**PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)**

1. PATIENT'S LAST NAME		FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME		5. MEDICAL RECORD NO. (Optional)		6. ONSET DATE	7. SOC. DATE
8. TYPE: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> RT <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.)		10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS (Short Term)				PLAN	

OUTCOME (Long Term)

13. SIGNATURE (professional establishing POC including prof. designation)

14. FREQ/DURATION (e.g., 3/Wk x 4 Wk.)

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE  N/A

17. CERTIFICATION  
FROM \_\_\_\_\_ THROUGH \_\_\_\_\_ N/A

15. PHYSICIAN SIGNATURE

16. DATE

18. ON FILE (Print/type physician's name)

20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care. Reason for referral)

19. PRIOR HOSPITALIZATION  
FROM \_\_\_\_\_ TO \_\_\_\_\_  N/A

21. FUNCTIONAL LEVEL (End of billing period) PROGRESS REPORT

CONTINUE SERVICES OR  DC SERVICES

22. SERVICE DATES  
FROM \_\_\_\_\_ THROUGH \_\_\_\_\_

## INSTRUCTIONS FOR COMPLETION OF FORM HCFA-700

(Enter dates as 6 digits month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider (*i.e.*, 00-7000).
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - (*optional*) Enter the patient's medical/clinical record number used by the billing provider.
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day (*i.e.*, 120191). The date matches occurrence code 11 on the UB-82.
7. **SOC (start of care) Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-82).
8. **Type** - Check the type therapy billed *i.e.*, physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.
11. **Visits From Start of Care** - Enter the **cumulative total visits (sessions)** completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. (*Corresponds to UB-82 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab on the UB-82*).
12. **Plan of Treatment/Functional Goals** - Enter brief current plan of treatment goals for the patient for this billing period. Enter the major short-term goals to reach overall long-term outcome. Enter the major plan of treatment to reach stated goals and outcome. Estimate time-frames to reach goals, when possible.
13. **Signature** - Enter the signature (*or name*) and the professional designation of the professional establishing the plan of treatment.
14. **Frequency/Duration** - Enter the current frequency and duration of your treatment, *e.g.*, 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
15. **Physician's Signature** - If the form HCFA-700 is used for certification, the physician enters his/her signature. **If certification is required and the form is not being used for certification, check on ON FILE box in item 18.** If the certification is not required for the type service rendered, check the N/A box.
16. **Date** - Enter the date of the physician's signature only if the form is used for certification.
17. **Certification** - Enter the inclusive dates of the certification, **even if the ON FILE box is checked in item 18.** Check the N/A box if certification is not required.
18. **ON FILE** (Means certification signature and date) - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
19. **Prior Hospitalization** - Enter the inclusive dates of recent hospitalization (*1st to DC day*) **pertinent** to the patient's current plan of treatment. Enter N/A if the hospital stay does not relate to the rehabilitation being rendered.
20. **Initial Assessment** - Enter **only current relevant history** from records or patient interview. Enter the major functional limitations stated, if possible, in objective measurable terms. Include only relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.
21. **Functional Level** (end of billing period) - Enter the pertinent progress made and functional levels obtained at the end of the billing period compared to levels shown on initial assessment. Use objective terminology. Date progress when function can be consistently performed. When only a few visits have been made, enter a note indicating the training/treatment rendered and the patient's response if there is no change in function.
22. **Service Dates** - Enter the from and through dates which represent this billing period (*should be monthly*). Match the From and Through dates in field 22 on the UB-82. **DO NOT** use 00 in the date. Example: 01 08 91 for January 8, 1991.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0227), Washington, D.C. 20503.

**UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION**

*(Complete for Interim to Discharge Claims. Photocopy of HCFA-700 or 701 is required)*

1. PATIENT'S LAST NAME		FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN*
4. PROVIDER NAME			5. MEDICAL RECORD NO. (Optional)	6. ONSET DATE	7. SOC. DATE
8. TYPE: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> RT <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW		9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.)		10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
12. FREQ/DURATION (e.g., 3/Wk x 4 Wk.)					
13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS (Specify changes to goals and plan)			PLAN		
GOALS (Short Term)					
OUTCOME (Long Term)					
I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. <input type="checkbox"/> N/A <input type="checkbox"/> DC			14. RECERTIFICATION		
15. PHYSICIAN'S SIGNATURE		16. DATE		FROM	THROUGH <input type="checkbox"/> N/A
17. ON FILE (Print/type physician's name)					
<input type="checkbox"/>					
18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD (Clarify goals and necessity for continued skilled care)					

19. SIGNATURE (or name of professional, including prof. designation)	20. DATE	21. <input type="checkbox"/> CONTINUE SERVICES OR <input type="checkbox"/> DC SERVICES
--	----------	--

22. FUNCTIONAL LEVEL (at end of billing period - Relate your documentation to functional outcomes and list problems still present)

23. SERVICE DATES	
FROM	THROUGH

## INSTRUCTIONS FOR COMPLETION OF FORM HCFA-701

(Enter dates as 6 digits month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider (i.e., 00-7000).
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - (optional) Enter the patient's medical/clinical record number used by the billing provider. (This is an item which you may enter for your own records)
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day (i.e., 120191). The date matches occurrence code 11 on the UB-82.
7. **SOC (start of care) Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which remains the same on subsequent claims until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-82).
8. **Type** - Check the type therapy billed i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.
11. **Visits From Start of Care** - Enter the cumulative total visits (sessions) completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. (Corresponds to UB-82, value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab).
12. **Current Frequency/Duration** - Enter the current frequency and duration on treatment, e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
13. **Current Plan Update, Functional Goals** - Enter the current plan of treatment goals for the patient for this billing period. (If the same as shown on the HCFA-700 or previous 701 enter "same"). Enter the short-term goals to reach overall long-term outcome. Justify intensity if appropriate. Estimate time-frames to meet goals, when possible.
14. **Recertification** - Enter the inclusive dates when recertification is required, even if the ON FILE box is checked in item 17. Check the N/A box if recertification is not required for the type of service rendered.
15. **Physician's Signature** - If the form HCFA-701 is used for recertification, the physician enters his/her signature. If recertification is not required for the type of service rendered, check N/A box. If the form HCFA-701 is not being used for recertification, check the ON FILE box - item 17. If discharge is ordered, check DC box.
16. **Date** - Enter the date of the physician's signature only if the form is used for recertification.
17. **On File (means certification signature and date)** - Enter the typed/printed name of the physician who recertified the plan of treatment that is on file at the billing provider. If recertification is not required for the type of services checked in item 8, type/print the name of the physician who referred or ordered the service, but do not check the ON FILE box.
18. **Reason(s) For Continuing Treatment This Billing Period** - Enter the major reason(s) why the patient needs to continue skilled rehabilitation for this billing period (e.g., briefly state the patient's need for specific functional improvement, skilled training, reduction in complication or improvement in safety and how long you believe this will take, if possible, or state your reasons for recommending discontinuance). Complete by the rehab specialist prior to physician recertification.
19. **Signature** - Enter the signature (or name) and the professional designation of the individual justifying or recommending need for care (or discontinuance) for this billing period.
20. **Date** - Enter the date of the rehabilitation professional's signature.
21. Check the box if services are continuing or discontinuing at end of this billing period.
22. **Functional Level (end of billing period)** - Enter the pertinent progress made through the end of this billing period. Use objective terminology. Compare progress made to that shown on the previous HCFA-701, item 22, or the HCFA-700, items 20 and 21. Date progress when function can be consistently performed or when meaningful functional improvement is made or when signification regression in function occurs. Your intermediary reviews this progress compared to that on the prior HCFA-701 or 700 to determine coverage for this billing period. Send a photocopy of the form covering the previous billing period.
23. **Service Dates** - Enter the from and through dates which represent this billing period (should be monthly). Match the From and Through dates in field 22 on the UB-82. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0227), Washington, D.C. 20503.